



Narratives, health and illness

MICHAEL MURRAY

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CONTENTS

PREFACE

PART I

1. BACKGROUND AND POTENTIAL

2. STORIES ALL THE WAY DOWN: THE NARRATIVE CONSTRUCTION OF HEALTH AND ILLNESS

3. ILLNESS: A STORY IN SEARCH OF A NARRATOR

4. LEVELS OF NARRATIVE ANALYSIS IN HEALTH PSYCHOLOGY

5. CONNECTING NARRATIVE AND SOCIAL REPRESENTATION THEORY IN HEALTH RESEARCH

PART II

6. MAKING SENSE OF NARRATIVE ACCOUNTS

7. ANALYSING NARRATIVE ACCOUNTS

8. NARRATIVE PSYCHOLOGY AND NARRATIVE ANALYSIS

9. NARRATIVES ABOUT DISEASE AND THE BODY

10. CANCER STORIES

11. NARRATIVE ACCOUNTS OF INJURY

PART III

12. STUDYING SOCIAL NARRATIVES AND CHANGING SOCIAL REPRESENTATIONS

13 FROM NARRATIVES OF RESISTANCE TO SOCIAL REPRESENTATIONS OF OPPRESSIONS AND VICE VERSA

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PREFACE

This booklet contains a selection of articles that I have written on narrative over the past ten years. They are largely unedited and reflect my thinking at the time. There is duplication of material across papers. In the future, depending upon time and interest, it is my intention to review and revise such that the collection provides a more coherent introduction to narrative health psychology.

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Part I

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 Harré 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. (p.)

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)

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, middle and an end.

In view of this background, it is not surprising to find that attributional 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" that 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 interpretative 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 is 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, and that therapy takes so long.

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).

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 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. It is this enveloping and constituting function of stories that is especially important to sense more fully. We are, each of us, locations where the stories of our place and time become partially tellable. (p.127)

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 this low-ranking knowledge, this

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 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

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 accounts 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 illustrates "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 instil 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, DeVecchio 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

STORIES ALL THE WAY DOWN: THE NARRATIVE CONSTRUCTION OF HEALTH AND ILLNESS

Introduction

Interest in the potential value of the narrative approach in helping our understanding of the experience of illness continues to grow. The purpose of this paper is to review some of this work and to highlight opportunities for new work. In reviewing the literature I was reminded of the story about Wittgenstein (or maybe it was about Bertrand Russell or maybe some Indian mystic). In being asked to clarify where language stops and physical reality begins he is supposed to have replied "I'm sorry, it's turtles (or maybe it was elephants) all the way down." I have attempted to expand this image to consider the narrative construction of illness within three broad levels of analysis: personal, interpersonal, and social.

Background

The past ten to fifteen years has seen a rapid increase in interest in the study of narrative across all of the social sciences. While literary theorists can trace interest in the study of narrative back to Aristotle's *Poetics* it was not until the 1980s that interest in narrative spread to other disciplines.

Although many narrative

psychologists might argue that their research has always involved the study of narratives it was not until the late 80s that a series of publications made this research perspective more self-conscious. Foremost among these publications were:

Actual Minds, Possible Worlds by Jerome Bruner (1986) in which he developed the argument for the existence of two forms of thought: the scientific and the narrative;
Narrative Psychology: The Storied Nature of Human Conduct edited by Theodore Sarbin (1986) in which Sarbin himself developed the idea of narrative as a root metaphor;
Narrative Knowing and the Human Sciences by Donald Polkinghorne (1988) in which he considers a range of topics from Paul Ricoeur's philosophical conception of narrative through to the therapeutic implications of narrative. (See Murray, 1997a, b and 1998 for more details)

The publication of these books generated an enormous amount of discussion not least because they provided an alternative conceptual framework to many psychologists who become disenchanted with mainstream positivist psychology. It also provided

a theoretical framework for those psychologists who were uneasy about what seemed to be the conceptual weakness of those who were involved in qualitative research.

The narrative turn provided a link with researchers in other disciplines. It questioned the disciplinary demarcation which separated psychology from debates in philosophy and literature on the one hand and from history and the social sciences on the other. There was increased debate about the commonalities rather than the differences between these disciplines and the historical nature of their development.

In very basic terms, narrative psychologists argue that narrative construction is a popular means of making sense of the world. The process of making a narrative enables the person to give meaning to the constant change in our lives, to bring order to disorder. As such, it would seem that narrative, and the study of narrative, was ideally suited to making sense of the disruption in people's lives following the onset of illness.

This paper reviews some (but by no means all) of the literature on illness narratives within three broad levels of analysis (see Murray, 1993 for further discussion of levels of analysis). It should be emphasized that the use of these levels is not intended to typify the particular studies since most of them straddle the various levels. Rather the intention is to investigate the various dimensions

within which narratives are constructed.

Personal level

Although not explicitly referring to narrative Michael Bury's (1982) innovative paper entitled "Chronic illness as biographical disruption" can be taken as a starting point for narrative research into illness. As the title suggests, this paper describes chronic illness as a particular kind of disruptive event in the sick person's personal biography "where the structures of everyday life and the forms of knowledge which underpin them are disrupted" (p.169). Thus, the individual begins to establish an understanding of chronic illness within the context of this personal disruption.

Subsequent researchers have considered the various psychological strategies used by individuals to reorganize their lives after such disruption. For example, Corbin and Strauss (1987) have described what they term the 'biographical work' in which the sick person engages, while Charmaz (1987) has used the term 'identity reconstitution' to describe how the person rebuilds his or her identity after illness (see Carricaburu and Pierret, 1995)

Gareth Williams (1984) in his paper entitled 'The genesis of chronic illness: narrative reconstruction' was one of the earliest researchers to explicitly refer to the role of narrative as a strategy the sick person uses to manage the biographical disruption

caused by the illness. He writes:
if biography connotes the indeterminate, reciprocal relationships between individuals and their settings or milieux, and between these milieux and the history and society of which they are a part, then narrative may be seen as the cognitive correlate of this, commenting upon and affirming the multiform reality of biographical experience as it relates to both self and society. (p. 178)

He continues:

sometimes the orderly sequence of facts gets broken up. It cannot be sustained against the chaos and, for a time at least, the life-course is lost. The routine narrative expressing the concerns of the practical consciousness as it attends to the mundane details of daily life is pitched into disarray: a death in the family, serious illness, an unexpected redundancy and so forth. From such a situation narrative may have to be given some radical surgery and reconstructed so as to account for present disruption. Narrative reconstruction, therefore, represents the workings of discursive consciousness. (p. 178)

Williams gave three examples of different form of narrative reconstruction: as political criticism, as social psychology, and as the

transcendence of causality. In each of these examples Williams illustrates the linkage of the present, the past and self with society. This linking of self with society was a process which Bury (1991) also emphasized in a later discussion of biography when he wrote:

The notion of biography suggests that meaning and context in chronic illness cannot easily be separated. (p. 453)

Unfortunately, this process of separation is exactly what many health psychologists have attempted to do in their study of health beliefs.

Other researchers have considered the structure of the illness narratives. For example, Robinson (1990) analysed a sample of 50 written accounts of people with multiple sclerosis. Using the analytic framework suggested by Gergen and Gergen (1986) he classified 26 of the accounts as progressive, 10 as stable, 5 as regressive and the others as unclassifiable. 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.

There are also the therapeutic implications of narrative construction. This is illustrated in an analysis of the

written accounts of a sample of women who had breast cancer by Murray (1997). The accounts were organized into a similar storyline with a beginning, middle and an end. The beginning was the period before cancer which was often characterized as a time of innocence. The middle of the story was the diagnosis and the subsequent medical treatment. The end was the period of reassessment of identity and reintegration into society. In doing these stories the women frequently emphasized the positive features of having cancer - it had given them an opportunity to reassess their lives. It was also apparent that the women were aware of the therapeutic benefits of telling these stories. Through the process of emplotment the women were able to take control over a crisis event and transform it into a life enhancing moment.

These researchers considered the psychological dimensions of illness narratives within the social. One important characteristic of narratives is the way they also connect the psychological with that of the physical and express the very embodiment of sickness. Becker (1997) suggests that in cultures where sensation and bodily expression is valued we can have direct access to the illness experience. In Western society, she argues "narrative is our primary means of accessing the bodily experience and is essential to our understanding of that experience" (p. 26).

Similarly, Arthur Frank (1995) in his classic text entitled "The

Wounded Healer: body, illness and ethics" argues that "the stories that people tell come out of their bodies ... the personal issue of telling stories about illness is to give voice to the body, so that the changed body can become once again familiar in those stories" (p. 2).

Interpersonal level

One problem with much research into illness narratives is that they have often been conceptualized as belonging to the narrators and so ignore their performative character. Discursive psychologists have adopted a more interactionist approach to the study of narrative emphasizing the importance of the immediate interpersonal context within which narratives are constructed. In the words of Stephen Tyler (1986) this approach:

privileges discourse over text, it foregrounds dialogue as opposed to monologue, and emphasizes the co-operative and collaborative nature of the [ethnographic] situation in contrast to the ideology of the transcendental observer. In fact, it rejects the ideology of 'observer-observed', there being nothing observed and no-one who is observer. There is instead the mutual, dialogical production of a discourse, of a story of sorts. (p. 126).

Elliot Mishler was one of the first to stress the interpersonal character of narrative production. In

his classic work entitled "Research Interviewing: Context and Narrative" (1986) he argues that because of the neglect of the social context on the character of the interview narrative researchers have not advanced our understanding much beyond that of mainstream survey researchers.

Mishler asked a series of questions

1. How do an interviewer's questions assessments, silences and responses enter into a story's production?
2. How do stories told in interviews differ from those told in other contexts, such as naturally occurring conversations?
3. Do different types of interview and question formats produce different types of stories?
4. How can the presence and influence of an interviewer be taken into account in the analysis and interpretation of a respondent's story?

Mishler argued that the narrative interview is a joint enterprise in which the two participants are both involved in the creation of the narrative. He referred to the innovative work of Marion Paget who writes that the distinctive feature of the all in-depth interview is "that the answers given continually inform the evolving conversation".

Catherine Riessman (1990) has extended this interpersonal critique of Mishler. She introduces Goffman's (1959) concept of impression

management which considers that social behaviour can be described as a performance which the actor adjusts to present a certain image to the audience. Admittedly, Riessman (1990) wishes to avoid the accusation levelled at Goffman that he held a rather manipulative and Machiavellian view of the social actor. She argues basically for a dialogical narrative conception of self through a detailed analysis of one man's account of his illness. Riessman concludes

by retelling consequential events and elaborating on their meanings, [this man] guides the impression that he gives, sustaining a reality, and a self, one that is sealed within the narrative. (p. 1199)

In the rush to obtain patient narratives the role of the researcher in the production of the narratives has often been neglected. Recently, Radley and Billig (1996) have renewed discussion of this vital issue in their call for a shift in researchers' attention from 'beliefs' to 'accounts'. They argue that "in offering views, people are also making claims about themselves as worthy individuals, as more or less fit participants in the activities of the social world" (p. 221).

Radley and Billig draw attention to an often ignored feature of research into illness experience - the health status of the researcher. Usually the researcher is healthy. Thus the sick person is placed in a position of having to justify his or her sickness so as to avoid the accusation

of being a malingerer or being a habitual complainer. To understand the narrative requires an understanding of the discursive context.

Admittedly, it is important to emphasize that this discursive context does not exist simply on one's conversation but is all around us. As Frank (1995) states:

The ill body's articulation in stories is a personal task but the stories told by the ill are also social. The obvious social aspect of stories is that they are told to someone, whether that other person is immediately present or not. Even messages in a bottle imply a potential reader. (p.3)

Consider again, the published accounts of breast cancer previously mentioned. These accounts were not simply written for the authors themselves but were written on the assumption that they would be read. As such, the authors structure their stories to convey a certain message. As Frank (1995) stated:

People tell stories not just to work out their own changing identities, but also to guide others who will follow them. They seek not to provide a map that can guide others - each must create his own - but rather to witness the experience of reconstructing one's own map. Witnessing is one duty to the commonsensical and to others. (p. 17)

The women in the breast cancer stories explicitly stated their need to tell others, to give witness.

Another aspect of the interpersonal character of narratives is their perceived legitimacy. Not all stories are equal. In modern society, to quote Frank (1995), "the story of illness that trumps all others ... is the medical narrative". The medical doctor can deny the legitimacy of the patient's story or shape it to another form. Clark and Mishler (1992) considered the case of stories patients tell their physicians. To illustrate their argument that the narrative is a shared account they consider two interviews. The former is restricted and disjointed and reflects the voice of medicine whereas the second is extensive and reflects the voice of the lifeworld. Clark and Mishler conclude that they:

would caution against the risks of reifying patients' stories. A patient's story is a specific narrative reconstruction of illness constituted within a specific social interaction at a particular time and place. What is included in the story and the way in which it is expressed results from contingencies of that interaction and, in turn, shapes that interaction. (p. 369)

Howard Waitzkin and his colleagues (Waitzkin, Britt and Williams, 1994) illustrate the way in which the physician shapes the character of the patient's narrative account through discouraging reference to the social and contextual

aspects of the illness, viz.:

In these ways, the discourse maintains ideological assumptions that value individualism and social attempts to cope with adversity. Critical exploration of alternative arrangements to enhance (her) social support does not occur. After the medical encounter, the patient returns to the same contextual problems conditions that trouble her, consenting to social conditions that confront the elderly in this society. (p. 336)

Thus the physician shapes the patient's narrative to match with broader social assumptions.

Finally, some researchers have considered how the therapist implicitly uses a narrative framework to orient the client to certain therapeutic goals. Cheryl Mattingly (1994) in her analysis of the work of occupational therapists argued that "healers actively struggle to shape therapeutic events into a coherent form organized by a plot. They attempt to emplot clinical encounters by enfolding them into larger developing narrative structures" (p. 811). Mattingly borrows the term emplotment from Paul Ricoeur who was particularly concerned about the structure of textual accounts. Mattingly deliberately extends this concept to consider the structure of social action. She argues that human action requires emplotment.

We are motivated, as actors, to

create stories while in the midst of acting. Locating ourselves within an intelligible story is essential to our sense that life is meaningful. (p. 812)

Within the therapeutic encounter the central task of the therapist is to set a story in motion which is meaningful to the patient as well as to herself..."to create a plot in which the ending toward which one strives involves a sense of what it means to be healed when one will always be disabled" (p. 814).

Social/Cultural level

These studies of the role of the professional in the shaping of illness narratives connect the study of narratives to the broader socio-cultural context. In one early commentary on the broader social character of narratives, Miller Mair (1981), the British psychotherapist, wrote:

Stories inform life. They hold us together and keep us apart. We inhabit the great stories of our culture. We are lived by the stories of our race and place. It is this enveloping and constituting function of stories that it is especially important to sense more fully. We are, each of us, locations where the stories of our place and time become partially tellable. (p. 127)

Narratives are constructed within and contribute to the development of the broader socio-cultural context. As such

investigations of narratives inform us of the cultural assumptions which permeate our identity. For example, an important component of the Western conception of the self is the sense of continuity and coherence. Illness or any traumatic event disrupts this continuity while narrative provides a means of restoring coherence. In her study of disrupted lives Gay Becker (1997) suggests

the strength of the ideal of continuity and its pervasiveness suggest that in the United States disruption to life may seem all the more abrupt because of the tendency to view life as a predictable, continuous flow. (p. 7)

A related concept is that of congruence between expectations and perceived actualities which Freeman (1997) argues is part of the Western sense of self. In a study of pain narratives among elderly people which I conducted (Murray et al, 1998) a sense of acceptance of pain was associated with that of moral congruence. Returning to Bury's ideas on biography, the acceptance of pain depended on the degree of integration of pain into the senior's life story.

An important issue is the extent to which the dominant cultural narrative meshes with the lived experience of people. According to White and Epstein it is the lack of fit between the dominant narrative and the lived experience of people which leads to distress. The role of narrative therapy to undermine the dominant

narrative which makes certain experiences problematic and to begin to build a new story which enhances alternative knowledge. They quote Foucault to the effect that "it is through the re-emergence of these low-ranking knowledge, these unqualified, even directly disqualified knowledge ... that criticism performs its work" (p. 82).

However, the therapeutic implications of narrative should not be confined to the dyadic setting. Within a community it is also possible to develop an alternative narrative. Farmer (1994), in his study of the social construction of alternative models of AIDS in Haiti, argued that this occurred through the transmission of stories about the disease. Instead of accepting the blame which was implicit within the dominant narrative, the Haitians used stories to create an alternative narrative which accused the United States of having sent AIDS to Haiti.

In a final study, Mogensen (1997) produced similar findings in his study of AIDS narratives among the Tonga of Zambia. He begins by emphasizing the interaction between experience and narrative:

Narrative should be seen as dialectical in the sense that not only do narratives structure lived experience but experience also structures narratives which therefore constantly change. Narratives thus provide a means of exploring how constructions of the concrete

and the personal are grounded in culture, as well as how individual experience transforms and participates in the creation of shared knowledge. (p. 432)

Mogensen showed how the Tonga were able to interweave their interpretation of AIDS with that of Kohungo, a local sexually transmitted disease. However, rather than accepting blame for the transmission of AIDS they emphasized the rapid change their society was undergoing. For example, they would say "AIDS has come through business men and women who go to different towns where they mix with many people" (p. 437). Mogensen (1997) realizing the social and historical nature of the narratives produced concludes:

However, one should not forget the reading of the world revealed in the interpretations of AIDS presented here, is a reading by certain people, experienced in a given context at a given time, and expressed in a given context at a given time. (p. 437)

This comment brings together the socio-cultural and the interpersonal

character of narrative.

A final feature to refer to is the historical location of our narratives. In the so-called modern era the medical narrative became the supposed voice of truth with respect to health and illness. Other voices were denigrated.

A feature of our late modern era is the questioning of such truths. This is reflected not only in the patients' demands to have their story told but also in the growing interest in the study of illness and other narratives.

Conclusion

These are just a few examples of what is a rapidly growing literature on illness narratives. What I have attempted to stress that while narratives may be defined as personal attempts to make sense of disruptions in individual biographies they are also social performances. The narrator tells his or her story to someone who may be real or imagined and he or she also tells it within a certain socio-historical context. The researcher must consider these broader dimensions of narrative

CHAPTER 3

ILLNESS: A STORY IN SEARCH OF A NARRATOR

What is health? What is illness? An answer to these questions is of central concern to all health psychologists. To those trained in the positivist tradition they are biopsychosocial phenomena the dimensions of which can be measured with varying degrees of reliability and validity using various scales and questionnaires. Much of positivist health psychology is concerned with developing and improving these measures and with investigating associations between them and how they change over time.

Health psychologists who adopt a non-positivist stance define health and illness as both a lived experience and a social construction. As such everyday language plays a central role in the defining their very character. This chapter is concerned with narrative as one form of discursive characterization of illness. According to narrative psychology (e.g. Sarbin, 1986) we are all storytellers and we live in a storied world. Narratives or stories pervade our everyday life such that we interpret the world and define ourselves through stories.

The past decade has seen an increased interest among a wide range of social scientists in the use of narrative as an analytic and

interpretive framework. Previously (Murray, 1997a, b), I have discussed the historical background to the use of this concept within psychology in general and its potential within health psychology. In this chapter, the aim is to introduce some of the philosophical and literary background to the use of this concept. In particular, I will refer to the work of the hermeneutic philosopher Paul Ricoeur and the literary critic Peter Brooks. Their ideas will be used to explore a range of examples taken from various contexts.

Time and narrative

Paul Ricoeur, who describes his work as philosophical anthropology, has made an immense contribution to our understanding of narrative particularly through his three volume work entitled *Time and Narrative*. Even for the trained philosopher this can be a difficult work (Reagan, 1997) mixing analytic philosophy with French and German literary theory and historiography. Fortunately, he has also written a large number of more concise articles which have been collated (e.g. Valdes, 1994) and to which we will mostly refer. Indeed, I use a version of the title of one these articles (Ricoeur, 1987) as the title for this chapter.

We can begin with reference to Ricoeur's discussion of time as one of

the defining characteristics of life. We cannot separate ourselves from this process but we must make sense of it. How can we capture and describe the human experience of time? It would seem that faced with the unceasing passage of time all we can do is describe it through a series of "aporias". This was the problem faced by Saint Augustine. "What then is time?" he asks. "I know well enough what it is, provided that nobody asks me; but if I am asked what it is and try to explain, I am baffled" (Ricoeur, 1984; p. 7).

Narrative provides a means of overcoming this multiplying of aporias. It is the process by which we organize our experience of time. In doing so we provide it with meaning. Prior to narrative there is no sense of order. Narrative organizes and in doing so gives time meaning. Time and narrative are interwoven. "Time becomes human to the extent that it is articulated through a narrative mode, and narrative attains its full meaning when it becomes a condition of temporal existence" (Ricoeur, 1991a; p. 52).

Ricoeur (1981) contrasts the disorder of Augustine's definition of time with the order provided by Aristotle's concept of *muthos* or *emplotment* which brings order to our interpretation of the constantly changing world. Narrativity can be seen in terms of this opposition: the discordance of time (*temps*) and the concordance of the tale (*recit*) (p.466). Admittedly, concord is never

completely achieved since time does not stop. Rather the tension between order and disorder is part of life. "Tragedy is paradigmatic for this: no tragedy is without complications, with fickle fate, without terrible and sad events, without irreparable error committed in ignorance or by mistake rather than through evil-mindedness. If then concord wins out over discord, surely it is the battle between them that makes the story" (Ricoeur, 1983; p.436).

The central process in narrative is emplotment. This is the means by which we "re-configure our confused, unformed, and at the limit mute experience of time." Emplotment is the process by which we "extract a configuration from a succession" (Ricoeur, 1983; p.427). Emplotment provides order and meaning to the previous chaotic flow of events. It is the "synthesis of heterogenous elements" (Ricoeur, 1987; p. 426). It is not a finished event but an ongoing process. As new information arises the plot is accordingly adjusted.

The basic narrative has a beginning, middle and an end. The beginning introduces the participants, the middle describes the main action sequences and the end describes the consequences. Admittedly there are many twists and turns in this basic structure. The literary critic Northrop Frye (1957), who actually coined the term emplotment in his review of fictional plots, identified four archetypal plot structures, viz. comedy, romance, tragedy, and satire.

Although these were derived from an analysis of literary texts they can have wider currency. Kevin Murray (1985) has discussed the application of these plots in everyday life. He argues that at least in terms of Goffman's dramaturgical perspective these plots can not only apply to the actions of actors in the theatre but to humans in everyday action. Admittedly, when there are dramatic occasions in our lives the salience of such plot lines become more apparent. For example, in discussing the sudden death of Princess Diana it was commonplace to talk about a tragedy. However, there is substantial interweaving of literary imagery and everyday life such that we frequently make reference to such images and plots to help understand our world.

Many literary theorists and, more recently, psychologists have suggested other generic plot structures. For example, Gergen and Gergen (1986) proposed three broad narrative structures, viz. progressive, regressive and stable. In the post-modern era there is a cynicism about the degree of closure which the plot can attain. As Brooks (1984) argues: "we have, in a sense, become too sophisticated as readers of plot quite to believe in its orderings" (p. 314). Despite this skepticism there is still a need for meaning which the even partially completed narrative can provide. The narrative is always open to change. For this reason the meaning which it conveys can best be characterized as provisional in nature

(Rickard, 1994).

We not only arrange events in the narrative but we also assign different values to the same events. Events which were inconsequential or almost forgotten can assume central importance and, conversely, events which were at one time perceived as important can be relegated. Which events are recalled and which story is told depends upon a variety of factors (see Murray, 1997a, b).

Reading for the plot

Peter Brooks has explored further the nature of the plot both within fiction and everyday life. Probably his most influential work is "Reading for the plot: Design and intention in narrative" (Brooks, 1984). In this he argues that the creation and exchange of narrative is a necessary aspect of the human condition. He describes man as "a fiction-making animal, one defined by fantasies and fictions" (Brooks, 1994; p. 108). Narratives are part of our very being since "the structure of literature is in some sense the structure of mind" (p. 24). We cannot avoid this since the temporal nature of life requires that we organize our interpretation of the world in narrative form. He adds: "we constitute ourselves as human subjects in part through our fictions, and therefore ... the study of human fiction-making and psychic processes are convergent activities and superimposable forms of analysis" (p. 35-36). In everyday conversation we make use of literary terms. For

example, not only do we tell stories but we also open and close chapters and turn over new pages.

However, Brooks went further in examining the connections between literature and psychoanalysis. Both can be considered as forms of narrative which has a central role in providing meaningful order in the "flux of temporal existence" (Rickard, 1994). He writes of his dream of "a convergence of psychoanalysis and literary criticism because we sense that there must be some correspondence of literature and psychic process that aesthetic structure and form must somehow coincide with the psychic operations they evoke, activate, appeal to" (Brooks, 1991). This narrative re-reading of psychoanalysis rescues it from the very mechanistic interpretation which has been more commonplace. Subsequently, we can see the value of this re-reading for a narrative understanding of illness.

Illness and narrative

Health and illness are part of life and hence exist in time. They are not static elements which can be extracted from time but are in constant flux and are given meaning by the stories we tell about them. Much of health psychology has ignored the temporal nature of health and illness. Certain forms of qualitative research have also ignored this central characteristic preferring to abstract pieces of text/discourse from both their social and temporal context. This is contrary to the narrative approach which 'does not fragment the text into discrete

content categories for coding purposes but, instead, identifies longer stretches of talk that take the form of narrative - a discourse organized around time and consequential events in a 'world' recreated by the narrator" (Riessman, 1990; p. 1195).

Let us consider an example. In August 1989, Anatole Broyard, an editor of the New York Times Book Review, was diagnosed with prostate cancer. The initial prognosis was positive and the medication he received seemed to be controlling the cancer. He continued to write his book reviews and contributed an article entitled "Intoxicated by my illness." In this article he describes his reaction to this disease. He adopted a questioning approach to the medical intervention and in April 1990 he gave a talk at Chicago Medical School describing his experience. This was subsequently revised and published as two articles entitled "Toward a literature of illness" and "The patient examines the doctor". Subsequently he began to physically deteriorate. Despite the nausea he experienced as a result of the medication he continued his writing until shortly before he died in October 1990. His writings were subsequently collected by his wife and published with an introduction by Oliver Sacks in 1992. His short account of his illness, from diagnosis through almost until death, provides a fascinating example of the role of narrative in making sense of illness.

In Broyard's case the disease was life-threatening. The very

diagnosis of cancer led him to a meditation on time: "I realized for the first time that I don't have forever. Time was no longer innocuous, nothing was casual anymore" (p. 4). He recalled the disconnectedness of his initial experience of cancer. Indeed, it was an attempt to remove this disconnectedness and the associated distress that drove him to transform it into a narrative. In "Toward a literature of illness" he describes how he strove to make sense of this crisis:

My initial experience of illness was a series of disconnected shocks, and my first instinct was to bring it under control by turning it into a narrative. Always in emergencies we invent narratives. We describe what is happening, as if to confine the catastrophe ... story telling seems to be a natural reaction to illness. People bleed stories, and I've become a blood bank of them. (p. 19)

Admittedly, Broyard was a literary critic and more attuned to narrative concepts. Let us take another example. This one is an account of the experience of Lupus provided to me by a woman we will call June. A large part of this account describes her repeated visits to a series of specialists all of whom suggested that there was nothing wrong with her and indeed that her complaint was psychological in nature. She began to worry about her mental health and experienced considerable distress. Finally, she was diagnosed with

Lupus. Although she recognized the serious nature of the disease she "felt as if a load was lifted from me".

Once June received the diagnosis she was able to think back over her life and to develop a narrative about the events which contributed to that diagnosis. In that sense, it was partly the end which determined the structure of the story. June described her early life especially her family life.

She had a drunken and abusive husband who provided little support to her raising six children. By middle age she felt she had attained some release since her children were raised and she was expecting grandchildren. However, one of her daughters miscarried and she felt very distressed. It was subsequently that she began to experience a range of symptoms which were eventually diagnosed as Lupus. Her final words in her record of her experience were "I honestly feel that my lupus was stress induced".

From the present, the diagnosis of Lupus, June creates a narrative in which she tied together the various stresses she experienced earlier in her life with the current condition and the prospects for the future. Her family problems which were endured now assumed a new importance as the cause of her disease. Her life had been transformed by the diagnosis. She is now a lupus patient. She attends meetings of the support group and discusses ways of helping fellow patients. Admittedly, her narrative is unfinished in the sense that the prognosis is uncertain.

Good and Good (1994) in their study of the illness narratives of Turkish people with epilepsy also commented on their unfinished nature. When a disease is chronic its future character remains uncertain. For this reason, the narrators can be described as being “situated in the midst of the accounts. Endings were often hypothetical; outcomes which were feared were juxtaposed against those desperately hoped for. Beginnings and previous experiences were subject to re-evaluation, as events unfolded, revealing the nature of the illness and its response to treatment” (Good and Good, 1994; p. 837).

Despite the variability and apparent contradictory nature of these narratives, they succeed through “subjunctivizing reality”. This is a term which Good and Good have taken from Bruner (1986) to describe the process whereby the author draws the reader into the indeterminacy of reality and suggests alternative endings, especially ones in which cure is possible. Good and Good (1994) identified several subjunctivizing elements in their stories. The first was that the narratives contained multiple perspectives and the potential for multiple readings. “Each story cast doubt on the others, or provides a potential alternative interpretation of the illness and of other stories about it. New experiences call for reinterpretation of past experiences and suggest new possibilities for the future, in life as in reading” (p. 839).

The second subjunctivizing

element was stories of encounters with the mysterious. Such stories hold up the hope that mysterious alternative forces exist which may provide healing. Although the medical establishment may offer little hope, there was always the prospect of recovery through the intervention of these other forces. Although June’s account did not make reference to mysterious forces it had many of the features of a quest. Much of her account is a story of her search for the diagnosis. She recalled that in her search she began to question her sanity. She entertained a variety of conflicting plots:

I’ve seen more doctors in the past years. I’ve been told it’s my nerves, my age, menopause, its all in my head, yet I was feeling sicker all the time. I kept thinking this must be how one feels in the late 50s or early 60s. (p.)

But now that she has the diagnosis she is able to reorder her life-history and her self-definition. She is a woman who, despite the disease or even because of the disease, is beginning to assert control over her life.

These examples are of individuals who were still in the midst of their illness. Previously, I reported an analysis of a selection of the published accounts of women who had had breast cancer (Murray, 1997b). These were the narratives of individuals who had come through an illness and, at least in medical terms, were now cured. These women

explicitly referred to the disorganization of their lives they had experienced as a result of their cancer and how writing their narratives as a means of restoring order. Some of the women referred to this ability to consign disorder and confusion to the past. For example, Betty Rollins (1976) says: "I wrote it to make myself seem 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). The very process of constructing the narrative enabled these women to, as it were, move forward.

It was apparent from reading these women's accounts that they preferred what Gergen and Gergen (1986) described as a progressive narrative. These accounts had a similar structure. The beginning described their lives before diagnosis of cancer. In describing this phase the women emphasized the carefree and innocence of their lives. This section closed with the diagnosis of cancer and the initial reactions of the women. The middle portion of the books focus on the medical treatment and the final portion concern their current situation.

In writing these accounts the women are constructing them from the end to beginning. They have survived cancer and now they recast their lives with reference to this experience. Looking back, the women select and order the incidents from their past. Freeman (1990) distinguished between a chronicle of past events and a

history. Whereas the former is simply a listing of past events, the latter requires the exercise of narrative reconstruction of those events. He reflects on the word "recollection": "while the '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" (Freeman, 1990; p. 47). The narrator organizes the narrative from a particular moment in time. Similarly, Mattingly (1994) in her discussion of illness narratives dwells on the selective and organizing nature of narrative. She says: "When we tell stories, we intensify and clarify the plot structure of events as lived, eliminating events that, in retrospect, are not important to the development of that plot - which do not, as we say, contribute to the ending" (p. 812). This process of selection and organization is done from the present and within a certain social context.

Telling and listening to stories

Narratives do not, as it were, spring from the minds of individuals but are social creations which serve the purpose of orienting the individual or group. We are born into a culture which has a ready stock of narratives which we appropriate and apply in our everyday social interaction. Ricoeur (1981) recognized this: "There can be no praxis which is not already symbolically structured in some way. Human action is always figured in signs, interpreted in terms of cultural traditions and norms. Our narrative

fictions are then added to this primary interpretation of figuration of human action; so that narrative is a redefining of what is already defined, a reinterpretation of what is already interpreted." (p. 469).

Narratives are situated and created within both the broader socio-cultural and more immediate interpersonal context. They cannot be abstracted from this context. Markova (1990), in her critique of traditional linguistic analysis, characterized it as "monologism". She emphasized the communicative nature of language the sense of which cannot be abstracted from their expressive context. "Dialogues, like any other kind of social interaction, are always embedded in particular socio-historical contexts that are themselves highly dynamic, be they cultures, institutions or the relationships of power that obtain between the participants" (p.1).

Similarly, Burkitt (1996) and Wortham (1996) in their critique of Mancuso (1996) emphasized the social context of discourse. Burkitt (1996) stressed the importance of the broader socio-cultural context within which personal constructs are developed. He noted that "the persons who construe are themselves constructs of a broader cultural and historical system and are locked in the interdependence of joint discursive practice."

Much previous work on health beliefs has failed to consider the social and cultural context within which they are embedded. Garro (1994), in her study of the stories people with

temporomandibular joint (TMJ) disorder use to described their condition, notes how people relate their individual accounts to broader cultural and shared models. The people she interviewed used a similar narrative framework to characterize their illness.

DelVecchio Good et al (1994) described how American oncologists have a cultural mandate to encourage a narrative of hope in their engagement with their patients. They achieve this by focusing on the immediate treatment plan rather than on the longer term and through this encourage the patient to invest energy in frequently arduous treatment programmes. This is also the message of popular medical books which are filled with the message of hope. Broyard comments on the books of Norman Cousins who, he says, "advises the patient to regard the diagnosis of critical illness not as a threat or a prophecy but as a challenge" (p.16).

The telling of stories is not only influenced by but also contributes to a social representation about a particular issue. This is illustrated in the work of Farmer (1994). In the early 80s, he conducted interviews about AIDS with residents of a Haitian community. Initially, there was little evidence of a shared representation of the disease. However, in the following years this silence gave way to considerable discussion as actual contact with individuals who had the disease increased. Informants began to

recount specific stories about individuals who had died of AIDS. Increasingly there was evidence of a sharing of these stories which Farmer took as an indication of the development of a collective model of AIDS.

Narratives are also constructed in an interpersonal context. There has been much debate recently about the frequent ignorance of the interpersonal context in psychological research. Leudar and Antaki (1996) have suggested the use of Goffman's (1979) concept of "footing" as a means of discussing how the different participants in the research project occupy shifting positions which need to be taken into consideration. This is an important point which emphasizes the social and active nature of discourse and, in our case, of narrative telling.

Brooks (1994) in his narrative re-reading of psychoanalysis focuses on the dialogic nature of the analyst-analysand interaction. While originally Freud was concerned with extracting, almost like a dental surgeon, the psychic cause of the analysand's distress, subsequently he began to consider the dialogic character of the narrative. In his "Constructions in analysis" Freud writes: "The analyst finishes a piece of construction and communicates it to the subject of analysis so that it may work on him; he then constructs a further piece out of the fresh material poring in on him, deals with it in the same way and proceeds in this

alternating fashion until the end" (cited in Brooks, 1994, p. 56)

The character of the relationship between the two partners in the discourse is of vital importance. Brooks (1984) writes: "the relation of teller to listener inherently is part of the structure and the meaning of any narrative text, since such a text (like any text) exists only insofar as it is transmitted, insofar as it becomes part of a process of exchange" (p. 50). Both partners have a particular perspective which they want to advance. In telling their stories the storytellers are conveying a particular viewpoint and trying to convince the other of that viewpoint. For example, Broyard states: "Like a convert who's had a vision, I wanted to preach it, to tell people what a serious illness is" (p. 21).

Stories are not only told but they are heard or read. The process of reading is not a passive process but an active one. As Ricoeur (1991b) says: "the process of composition, of configuration, is not completed in the text but in the reader and, under this condition, makes possible the reconfiguration of life by narrative" (p. 25). Thus the listener transforms the story. This is an important issue for researchers. Although the research participant may tell a particular story, which s/he may or may not agree with subsequently, the researcher then has to interpret that story. Ricoeur (1974) counterposes interpretation with explanation. Whereas explanation is proposed by positivist scientists as the

result of a supposed objective assessment of the information available, "interpretation has specific subjective implications, such as the involvement of the reader in the process of understanding and the reciprocity between text-interpretation and self-interpretation. This reciprocity is usually known as the hermeneutical circle" (p.303).

Interpretation of the narrative requires the process of appropriation which Ricoeur (1972) defines as the ability "to make one's own what was initially alien" (p. 89). He borrows from Gadamer the concept of play to explore appropriation. "We play with a project, with an idea; we can equally 'be played'. What is essential is the 'to and fro' of play. Play is thereby close to dance, which is a movement that carries away the dancer" (p. 90). Rudberg (1997) has used this analogy to help her interpret young people's accounts of their relationships. "The text invites one to dance - which means that the interpreter is both actively involved as well as responding to the movements of the partner - the dance has a logic of its own, you are not just dancing, you are danced with" (p.8). Further, she adds that "just like dancing, any interpretation of a text involves being seduced into following the text itself." Of course, the researcher has to be careful not to be taken in by far-fetched tales. "It is in the dialectics between 'letting go' and 'holding on' that interpretation works."

Through the process of

appropriation the researcher comes to know more not just about the research participant but also about herself. Admittedly, the more convincing narrators will be able to transport the reader more easily into their world. In everyday life we can often be taken in by tall tales. It is the task of the individual to challenge such tales. It is for this reason that Ricoeur (1972) talks of the "hermeneutics of suspicion".

Brooks (1994) also emphasizes the active constructive role of the reader or listener. He writes: "The process of listening to a story or reading a text is essentially constructive, a filling-in of gaps, a building of fragments into a coherent whole: a conquest of the non-narrative by the narrative, of non-sense by the semantic" (p. 57). The reader must enter into the narrative if he is to understand it. This is the nature of transference. This is the process by which the narrative is transferred from the teller to the listener and back again. Brooks critiques the traditional positivist reading of texts which tend to impose a model. "When you apply theory to texts it implies that you are putting some sort of grid over them, and that this may be quite reductive and limiting. I prefer to think in terms of an interference of two systems, where you start from two different places, one in the literary text, the other in theoretical considerations, and try to see what their merger looks like, and what happens as they start to contaminate one another, as you create a sort of effect of superimposition of

one on the other (and vice versa), which is what I try to do particularly in the use of psychoanalysis" (p. 105/6).

There is no definitive interpretation, rather multiple interpretations. In her work on the life stories of alcoholics Steffen (1997) makes a similar point. She draws on Jackson's (1989) critique of positivist science to suggest that "a story is ... suggestive rather than definitive of meaning. It begins in the experience of one person, but others make it over to themselves and give it new uses and interpretations" (p. 105).

But what then is the standing of competing narratives. Brooks (1994) argues that narrative truth "seems to be a matter of conviction, derived from the plausibility and well-formedness of the narrative discourse, and also from what we might call its force, its power to create further patterns of connectedness, its power to persuade us that things must have happened this way, since here lies the only explanatory narrative, the only one that will make sense of things" (p. 59).

As an alternative to a positive truth Brooks proposes a transferential truth which emphasizes the process of negotiation and exchange within the dialogue. "The truth of narrative is situational, the work of truth reciprocal. Wisdom comes from conviction, however, you construct it" (p. 101).

Narrative and life

There remains the question as to

whether human life, health and illness exist outside of narrative and whether narratives can be lived as well as told. Ricoeur (1987) argues that "a life is no more than a biological phenomenon as long as it has not been interpreted" (p.432). We can never have access to life except through narrative. While we can refer in an abstract sense to the pre-narrative quality of human experience, once we begin to think and talk about it we transform it through narrative. While we live in a material world it is one which we must interpret. Admittedly, it could be argued, as does Ricoeur (1987), that the world already has a type of structure which we organize into a narrative. He writes that "the configuration effected by narrative is not grafted onto something figureless, faceless, but upon a life in which narration structure is 'prefigured'" (p. 87).

Although Ricoeur (1987) emphasizes that life and narrative remain distinct he also suggests a reconciliation. "It is certainly true that life is lived and the story told. An unbridgeable distinction remains, but it is in part, abolished through our capacity to appropriate in the application of ourselves the intrigues we received from our culture, and our capacity of thus experimenting with the various roles that the favourite personae assume in the stories we love best" (p. 437).

Life and narrative are closely intertwined. While we live lives we simultaneously live within narratives

although we may not be aware of these. Ricoeur (1981) writes: "There can be no praxis which is not already symbolically structured in some way. Human action is always figured in signs, interpreted in terms of cultural traditions and norms. Our narrative fictions are then added to this primary interpretation of figuration of human action; so that narrative is a redefining of what is already defined, a reinterpretation of what is already interpreted. The referent of narration, namely human action, is never raw or immediate reality but an action which has been symbolized and resymbolized over and over again" (p. 469).

Narrative is constructed within a personal and social context. It not only draws meaning from that context but dialectically gives meaning to it. While disease exists in material terms we interpret and transform it through narrative. Narrative makes sense of disease within a personal and social context. It gives disease a personal history and places it within a particular social order. Broyard is amusing in constructing his personal disease history:

It's not unusual for the patient to think that it's his sex that is killing him and to go back over his amatory history for clues. And of course this is splendid material for speculation, both lyrical and ironical. My first reaction to having cancer was lyrical - irony comes later... I'm tempted to single out particular

women and particular practices that strike me now as more likely to be carcinogenic than others. (p. 26)

In telling his personal story Broyard is projecting a certain image of himself. Human identity is not something which is fixed but something which is created and recreated through the very process of narration. The sense of identity which defines the individual is derived from the very process of story telling. As Ricoeur (1981) states: "it is by trying to put order on our past, by retelling and recounting what has been, that we acquire an identity" (p. 467).

Although such an identity has a certain constancy it is not fixed. This is because "we do not cease to re-interpret the narrative identity that constitutes us in the light of stories handed down to us by our culture" (Ricoeur, 1987; p. 437). One problem which emerges here revolves around the changeability or variability of narrative identity. Does this imply that we are simply storytellers but have no fixed viewpoint? Riessman (1990) makes a similar point with reference to the lack of self in Goffman's (1959) concept of impression management in social situations. If we can always change our story to match the situation then what is left behind the mask. However, this is to abstract the individual from the context. The two remain in constant interaction.

The important point is that all stories emerge in dialogue either with

ourselves or others. At all time they convey a certain image of the narrator. For example, the women with breast cancer in recounting their cancer stories convey an image of themselves as women who were not, as it were, defeated by cancer. Rather they were women who 'defeated' cancer, at least temporarily.

Admittedly, in retelling these stories certain metanarratives have greater power than others. Ricoeur (1987) refers in particular to the role of literary, scientific and political modes of representation. These different modes condition the way we think about life such that "we learn to become the narrator of our own story without completely becoming the author of our life" (p. 437). This proposal allows the maintenance of a sense of personal identity and selfhood. When Brooks states: "We constitute ourselves as human subjects in part through our fictions" (p. 36) he was talking about the role of literature in our society. But we can add, it is also through the everyday exchange of stories by real living beings that we reaffirm our humanity and individuality.

Narrative, health and illness

While health and illness exist outside narrative we can only begin to understand them through narrative. Admittedly, certain illness narratives could be described as more healthy than others. Indeed, it is through narrative reconstruction that the personal character of illness can be

changed.

Brooks (1994) refers to the classic case history of Dora which was reported by Freud. This case illustrates the centrality of narrative within therapeutic process. Freud writes: "The connections - even the ostensible ones - are for the most part incoherent, and the sequence of different events is uncertain ... The patients inability to give an ordered history of their life in so far as it coincides with the history of their illness is not merely characteristic of the neurosis. It also possesses great theoretical significance." Through therapy these discontinuities are sorted out such that "it is only toward the end of the treatment that we have before us an intelligible, consistent, and unbroken case history" (cited in Brooks, 1994; p. 48). In a very evocative sentence Brooks repeats his argument: "*Mens sana in fabula sana*: mental health is a coherent life story, neurosis is a faulty narrative" (p. 49). It is through the process of constructing a more ordered narrative that the analysand begins to improve psychologically.

Ricoeur (1987) also comments specifically on the narrative character of psychoanalysis. He writes: "The client who turns to a psychoanalyst to present him with bits of lived histories, dreams, 'primitive scenes', conflicting episodes; one can indeed say that the goal and effect of the analytic sessions is that the person analyzed draws out from these bits and pieces a story that is both intelligible and more bearable"

(p. 435). It is the disconnectedness which Broyard referred to which causes the psychological distress. It is through the creation of a more coherent and non-threatening narrative that therapy achieves its impact. Broyard felt that the ability to transform his experience into narrative was beneficial:

Just as a novelist turns his anxiety into a story in order to be able to control it to a degree, so a sick person can make a story, a narrative, out of his illness as a way of trying to detoxify it. (p. 21)

Broyard continues that, at least in phenomenological terms, narrative construction brought order and meaning to the illness. It rescues it "from what Ernest Becker called the panic inherent in creation or the suction of infinity" (p. 20/21).

Through narrative the sick person begins to bring order to time. Broyard continues:

All cures are partly 'talking cures,' in Freud's phrase. Every patient needs mouth-to-mouth resuscitation, for talk is the kiss of life. Besides talking himself, the doctor ought to bleed the patient of talk, of the consciousness of his illness, as earlier physicians used to bleed their patients to let out heat or dangerous humors. (p. 54)

Admittedly, the individual does not require analysis to obtain the therapeutic benefits of narrative. This occurs in everyday social interaction as

we exchange and revise narrative accounts (Murray, 1997a).

This does not mean that narrative offers the promise of some miracle cure to disease. Rather it can be transformed psychologically. Broyard illustrates this process vividly. He recalls the autobiography of the British psychoanalyst D. W. Winnicott which begins with the statement "I died" and then continues five lines later with "Let me see. What was happening when I died? My prayer had been answered. I was alive when I died. That was all I had asked and I had got it". Broyard continues:

Though he never finished his book, he gave the best reason for writing one, and that's why I want to write mine - to make sure I'll be alive when I die. (p. 30)

In an epilogue his wife writes: "And yes, he was alive, as he had hoped, when he died" (p. 135).

Conversely, as Robinson (1994) found in his study of the written narratives of patients with MS people can be dead before they die. Their story has ended. While these examples may seem melodramatic they illustrate the linkage between narrative, illness and life. We are narrative beings. The stories we tell or are encouraged to tell can be either life enhancing or threatening. Through qualitative research health psychology can begin to understand the character and etiology of the various narratives which we use to order illness in our society.

CHAPTER 4

LEVELS OF NARRATIVE ANALYSIS IN HEALTH PSYCHOLOGY

Introduction

The past 10 to 15 years have seen a rapid increase in interest in the study of narrative across all of the social sciences. While literary theorists can trace interest in the study of narrative back to Aristotle's *Poetics* it is only recently that interest in narrative has spread to other disciplines. Although some psychologists might argue that their research has always involved the study of narratives, it was not until the late 1980s that a series of publications made this research perspective more self-conscious. Foremost among these publications were *Acts of meaning* by Jerome Bruner (1990) in which he developed the argument for the existence of two forms of thought: the scientific and the narrative; *Narrative Psychology: The Storied Nature of Human Conduct* edited by Theodore Sarbin (1986) in which Sarbin himself developed the idea of narrative as an alternative root metaphor to that of the machine that has dominated psychology; and *Narrative Knowing and the Human Sciences* by Donald Polkinghorne (1988) in which he considered a range of topics from Paul Ricoeur's philosophical conception of narrative through to the therapeutic implications of narrative (see Murray, 1997a, 1997b, 1999, for more details).

The publication of these books generated substantial discussion, not least because they seemed to provide an alternative conceptual framework for many psychologists who had become disenchanted with mainstream positivist psychology. This 'narrative turn' provided a link with researchers in other disciplines. It questioned the disciplinary demarcation that separated psychology from debates in philosophy and literature on the one hand and from history and the social sciences on the other. There was increased discussion about the commonalities rather than the differences between these disciplines and the historical nature of their development.

In very basic terms, narrative psychologists have argued that narrative construction is a popular human means of making sense of the world. The process of creating a narrative enables the person to give meaning to the constant change in his or her life, to bring order to disorder. As such, it would seem that narrative and the study of narrative was ideally suited to making sense of the disruption in people's lives following the onset of illness. The absolute profusion of published accounts of illness would seem to provide evidence of people's need to tell stories about their illnesses. Indeed, the

literary critic Anatole Broyard (1992), who subsequently died of cancer, wrote after his initial diagnosis that "... story telling seems to be a natural reaction to illness. People bleed stories, and I've become a blood bank of them" (p. 20). However, this is perhaps too simple an analogy since stories are not continuous and unchanging like blood flowing from a cut but rather have a certain shape and form. The challenge is to understand how this shape and form are decided. The Canadian sociologist, Arthur Frank (1998), has recently raised the issue as to what factors are involved in shaping the story. Since he himself was diagnosed with cancer, he has been fascinated with the nature of the stories that people tell about their illnesses. He was particularly enthusiastic about the therapeutic value of storytelling and for a period edited a journal that included patients' accounts. More recently he has begun to consider the ownership of these stories. Specifically, he asked the rhetorical question: "How was my story - and the stories other people tell - produced by power, and how was my story reproducing power?" (p. 330).

Frank was concerned with identifying the extent to which his own stories, and indeed all stories, were an opportunity for self-expression and self-care or merely the reproduction of broader power relations. To clarify this question he contrasted the ideas presented by Michel Foucault during his middle

period when he emphasized the various repressive forms of power with his later writings in which he offered what Frank describes as a more humanist approach. Frank concluded:

Situating illness narratives within relations of power does not obviate their use as a way that selves take care of themselves. On the contrary, bringing Foucault to the study of illness narratives expands our sense of what these stories are and what they can do. (1998, p. 345)

More recently, Horton-Salway (in press), using a framework suggested by Edwards (1997), has contrasted three types of analysis of narrative: one based upon a realist ontology which assumes that the narrative reflects the world, the second based upon a more cognitivist approach which stresses the constructive role of the narrative's author, and the third based upon a discursive approach which considers the interactive context within which the narrative is constructed.

This article seeks to continue this discussion about the character of narratives by considering the different levels of analysis that have been used to investigate stories within health psychology. Doise (1986), out of frustration at the lack of connection between different explanations within social psychology, proposed that one way of providing some clarity was to consider various explanations as being

at different levels of analysis. Specifically, he considered four levels of analysis: the 'psychological' or 'intrapersonal' level, which is concerned with how the individual interprets the world; the 'interpersonal' level, which considers the character of the interaction between individuals who are considered as interchangeable partners in a situation; the 'positional' level, which considers the different social positions of actors in situational interactions; and the 'ideological' level, which considers the broader belief systems. This conceptual structure provides a means of reviewing research on narratives within health psychology (see also Murray, 1993). At the outset, we should caution that this structure is merely a device for organizing the disparate research on illness narratives. As Doise emphasized: 'we are not talking about four different levels of reality, but four different levels of analysis' (1986, p. 11).

Personal level

At the personal level of analysis 'the theories describe how individuals organize their perception, their evaluation of their social milieu and their behaviour within this environment' (Doise, 1986, p.11). This level of analysis is very much in accord with the phenomenological approach which has tended to dominate much of narrative psychology. The contemporary version of this approach to the narrative study of illness begins

with the argument that we are all material beings. Frank argues that during sickness or after sickness it is not just the body but our very identity that is threatened. It is through storytelling that sick people begin to know themselves and their changed bodies. In his classic text entitled *The Wounded Storyteller*, Frank (1995) argues that 'the stories that people tell come out of their bodies ... the personal issue of telling stories about illness is to give voice to the body, so that the changed body can become once again familiar in those stories' (p. 2).

Within this level of analysis is also the argument that the stories told by the sick person have a personal function. As a form of self-care the personal stories are a means by which the sick person takes control over the illness, and so brings order to a chaotic world. This line of argument follows from the basic postulate of narrative articulated most clearly by Paul Ricoeur. He argued that since the world is in constant flux, humans need to use narrative strategies to bring order to the world. Through the process of emplotment the narrator 'provides "shape" to what remains chaotic, obscure, and mute' (Ricoeur, 1979, p. 115). Illness, particularly serious life-threatening illness, is an event that brings chaos to the everyday world of the sick person. It has been argued (Murray, 1997a) that one of the personal therapeutic functions of the illness narrative seems to be to remove guilt from the

narrator, or at least to assert the relative degree of responsibility. The narrator often describes the period before illness in almost idyllic terms. In particular, they stress their blamelessness. It is not their fault that they are ill.

Another therapeutic function of the illness narrative is the reconstruction of identity. Frank (1995) considers the reassessment of identity to be the central theme of all illness narratives. He argues that at the core of any illness narrative is an epiphany, after which the person reassesses his or her place in the world. This concern with personal identity is also a central concern of Paul Ricoeur's (1992) philosophy. He argues that identity has two aspects: *memete* and *ipseite*: selfhood and sameness. Selfhood is the way the individual defines him- or herself as separate from others, circumscribed in his or her individuality at any given time. Sameness refers to the fact that individuality is maintained through time. Through narrative the person organizes his or her life history and identity. It is through the very process of continuous narrative construction and reconstruction that the individual maintains a sense of personal identity. Things may change but there is still a narrator to tell the story. After illness the person seeks to reorganize the life history, to seek connections.

Bury (1982) presented a related argument. He described chronic illness as a particular kind of disruptive event in the sick person's personal

biography 'where the structures of everyday life and the forms of knowledge which underpin them are disrupted' (p. 169). Thus, the individual begins to establish an understanding of chronic illness within the context of this personal disruption to his or her life story. Subsequent researchers have considered the various psychological strategies used by individuals to reorganize their lives after such disruption. For example, Corbin and Strauss (1987) have described what they term the 'biographical work' in which the sick person engages, while Charmaz (1987) has used the term 'identity reconstitution' to describe how the person rebuilds his or her identity after illness (see Carricaburu and Pierret, 1995).

Gareth Williams (1984) was one of the earliest researchers to refer explicitly to the role of narrative as a strategy the sick person uses to manage the biographical disruption caused by the illness. He writes:

if 'biography' connotes the indeterminate, reciprocal relationships between individuals and their settings or milieux, and between these milieux and the history and society of which they are a part, then narrative may be seen as the cognitive correlate of this, commenting upon and affirming the multiform reality of biographical experience as it relates to both self and society. (p.178).

Williams gave three examples of different forms of narrative reconstruction: as political criticism, as social psychology, and as the transcendence of causality. In each of these examples Williams illustrates the linkage of the present, the past and self with society. This linking of self with society was a process that Bury (1991) also emphasized in a later discussion of biography when he proposed that “the notion of biography suggests that meaning and context in chronic illness cannot easily be separated” (p. 453).

At the personal level of analysis, the narrative is conceived as a means of getting to know the body and of reorganizing one’s identity. However, as Williams (1984) and Bury (1982) have argued, the self is not simply an embodied being but a social being who enjoys certain relations with others and exists in a certain sociocultural domain. The stories told are not simply expressions of the body or cognitive attempts to order the world but stories that are shaped by the social context within which they are expressed. These characteristics of narratives are considered by researchers working at more social levels of analysis.

Interpersonal level

This level of analysis is concerned with ‘interpersonal processes as they occur within a given situation’ (Doise, 1986, p. 12). Elliot Mishler (1986) was one of the first to stress the importance of this level of analysis in understanding the structure of narrative accounts. He

argued that some narrative researchers have not advanced our understanding much beyond that of mainstream survey researchers because they have neglected the role of the interview context in shaping the character of the narrative account. To encourage researchers to consider the importance of the interview context Mishler invited them to consider a series of questions including:

1. How do an interviewer’s questions, assessments, silences and responses enter into a story’s production?

2. How do stories told in interviews differ from those told in other contexts, such as naturally occurring conversations?

3. Do different types of interview and question formats produce different types of stories?

Within this interpersonal level of analysis, the narrative is viewed as the result of a joint enterprise in which the two participants are both involved. Mishler referred to the innovative work of Marion Paget (1983), who wrote that the distinctive feature of the in-depth interview is ‘that the answers given continually inform the evolving conversation’ (p. 78). In telling a story the person is participating in a conversation and as such must adjust and readjust the character of that story depending upon the reaction of the reader. Certain features are clarified and certain emphases added.

Catherine Riessman (1990) extended this interpersonal critique of Mishler. She introduced Goffman’s

(1959) concept of impression management which considered social behaviour as a performance in which the actor adjusts his or her behaviour to present a certain image to the audience. Admittedly, there is always the danger in emphasizing the changing nature of narrative within the conversation to attract the accusation levelled at Goffman that he held a manipulative and Machiavellian view of the social actor. The alternative is to propose a dialogical narrative conception of self whereby the author is constantly involved in the social construction of identity through the process of narrating his or her life to others.

This interpersonal level of analysis can extend beyond the immediate situation to a much wider arena. As Frank (1995) stated: "Even messages in a bottle imply a potential reader" (p. 3). Consider the published accounts of breast cancer which have become quite popular and which are considered in detail elsewhere (Murray, 1997a). These accounts were not simply written for the authors themselves but were written on the assumption that they would be read. As such, the authors structured their stories to convey a certain message. This message was designed to convey the process of change, of coping with the disease. Frank (1995) described the process of publicly telling about one's illness as 'witnessing'. The women in the breast cancer stories explicitly stated their need to tell others, to give witness. They wished to tell the world,

and themselves, that cancer did not mean death. Indeed, there was life after cancer. We can even go further and argue that in the postmodern world when established wisdom is questioned this giving of witness is part of a general social responsibility. Frank (1995) described it as 'the core morality of the postmodern' (p. 17).

Finally, Horton-Salway (in press) considered the discursive character of narrative accounts of myalgic encephalomyelitis (ME). She argued that in giving their narrative accounts these participants were involved in 'rhetorical work' which is distinct from the 'impression management' of Goffman which tends to suggest intentional concealment. For example, in providing a description of a healthy life before illness, Horton-Salway argued that the participants in her study were engaged in a process of contrastive accounting whereby they attempted to undermine the popular psychosomatic account of ME. She emphasized that these narrative accounts had a particular meaning within the conversational context.

While analysis at the interpersonal level brings to the fore the importance of the conversational context within which the narrative accounts is produced, there is a need also to consider the particular characteristics of the participants.

Positional level

Each partner in social interaction brings to that interaction certain social characteristics. The relevance of these

characteristics is considered by researchers working at the positional level of analysis which extends the interpersonal level to include 'differences in social position which exist prior to the interaction between different categories of subject' (Doise, 1986, p. 13). At this level of analysis we can consider work on the character of the participants in the research interview and in the clinical interview.

Radley and Billig (1996) have drawn attention to the health status of the researcher in the research interview. Usually the researcher is healthy. Thus the sick person is placed in a position of having to justify his or her sickness so as to avoid the accusation of being a malingerer or a habitual complainer. To understand the narrative requires an understanding of the positional context. Radley and Billig have argued that in the research interview 'people are (also) making claims about themselves as worthy individuals, as more or less "fit" participants in the activities of the social world' (1996, p. 221).

In a recent study of elderly people's pain narratives, Murray, LeFort, and Ribiero (forthcoming) also considered the positional context. In this study a young female researcher conducted some of the interviews with the seniors. In analysing these interviews the importance of the social positions was noted. For example, one woman expressed the difficulty she found in telling the young interviewer about the nature of her pain. She said

at one point: 'See, this is what I shouldn't say. I don't like this'. In detailing her pain experience this elderly woman felt that she was presenting herself as a complainer, something which she found objectionable, at least in that context.

Research on narrative and the clinical encounter is another example of the 'effects of differences in social position' (Doise, 1986, p. 13). Clark and Mishler (1992) considered the case of the stories that patients tell their physicians. These were described as restricted and disjointed and reflected the dominant voice of medicine. This was in contrast to the extensive narrative accounts provided in other contexts and which were said to reflect the voice of the patient's lifeworld. Clark and Mishler concluded that investigators should guard against reifying patients' stories. They argued that:

A patient's story is a specific narrative reconstruction of illness constituted within a specific social interaction at a particular time and place. What is included in the story and the way in which it is expressed results from contingencies of that interaction and, in turn, shapes that interaction. (p. 369)

Thus, the story told by the patient in the clinical encounter contains within it certain features of that encounter.

Finally, some researchers have considered how the therapist implicitly uses a narrative framework to orient the client to certain thera-

peutic goals. Cheryl Mattingly (1994), in her analysis of the work of occupational therapists, argued that 'healers actively struggle to shape therapeutic events into a coherent form organized by a plot. They attempt to emplot clinical encounters by enfolding them into larger developing narrative structures' (p. 811). Mattingly borrowed the term *emplotment* from Paul Ricoeur, who was particularly concerned about the structure of textual accounts. Mattingly deliberately extended this concept to consider the structure of social action. She argued that human action requires *emplotment* since "we are motivated, as actors, to create stories while in the midst of acting. Locating ourselves within an intelligible story is essential to our sense that life is meaningful" (p. 812). Within the therapeutic encounter the central task of the therapist is 'to set a story in motion which is meaningful to the patient as well as to herself [...] to create a plot in which the "ending" toward which one strives involves a sense of what it means to be healed when one will always be disabled' (p. 814). However, the health professional has a very powerful role in shaping the character of that story.

At the interpersonal and positional levels of analysis, narrative is conceived as a joint action. It is not simply the property of the single narrator but of two or more individuals. These individuals need not be physically present. However, these interpersonal encounters do not

exist in a void. The studies that have investigated encounters with professionals illustrate how broader ideological assumptions pervade everyday life and the stories that people tell. This leads to studies at the ideological level of analysis.

Ideological level

This level of analysis is concerned with a society's 'own ideologies, its own systems of beliefs and representations' (Doise, 1986, p. 15). Research on social representations is of particular importance in this level of analysis. Social representation theory is concerned with exploring the broader sociocultural assumptions that condition a society's or a community's everyday thoughts and practices. Two central processes in social representation theory are anchoring and objectification. Anchoring is the process by which unfamiliar concepts are given meaning by connecting them with more familiar concepts, whereas objectification is the process whereby a more abstract concept acquires meaning through association with a more everyday phenomenon.

The classic study of social representations of health and illness was that conducted by Herzlich (1973; see also Flick, 2000). In this study, Herzlich conducted interviews with a sample of French adults about their views on health and illness and identified certain shared conceptions of health and illness. However, as Laszlo (1997) emphasized, Herzlich ignored the narrative qualities of these

interviews, preferring to identify categorical anchoring and objectification of health and illness. The challenge is to consider the character of the narrative accounts revealed in such interviews and how they are integrated into and transform social representations.

Laszlo, in his analysis of the narrative organization of social representations, referred to Maurice Halwach, a student of Durkheim (who developed the concept of collective representations). Halwach argued that narratives play a role in constructing and organizing everyday social experiences. It is through the sharing of stories about everyday experiences, such as about illness, that a community creates a mutually intelligible world. As such, investigation of narratives informs us of the cultural assumptions that permeate our society and our very identity. Flick (1995) introduced the concept retrospective anchoring which was a means of connecting interpretations of contemporary phenomena with those of past events and integrating them into social representations. He suggested that since narratives are concerned with reconstructing past events they are intimately involved in the process of retrospective anchoring. It is through the exchange of narrative accounts of particular illness episodes that a community develops a social representation of that illness.

Farmer (1994), in his study of cultural representations of AIDS in

Haiti, asked the question: 'How do illness representations, and the realities they organize and constitute, come into being?' (p. 806). He answered that it was through the telling of stories about the disease. These stories became shared and are then, in turn, used to explain subsequent illness episodes. Morgensen (1997), in his study of AIDS narratives among the Tonga people of Zambia, also emphasized the central role of these narratives in shaping social representations. He emphasized the interaction between experience and narrative in the production of social representations:

Narrative should be dialectical in the sense that not only do narratives structure lived experience but experience also structures narratives which therefore constantly change. Narratives thus provide a means of exploring how constructions of the concrete are grounded in culture, as well as how individual experience transforms and participates in the creation of shared knowledge. (p. 432)

We live in a world that is mediated to us through stories that are spoken, written and acted. Discussion of narrative accounts at the societal level cannot ignore those contained in literature and the media. Sarbin (1997) has considered how certain literary stories take on particular mythic qualities in different societies. He discussed what has become known as

the Quixotic principle after the famous literary figure Don Quixote who modelled himself on literary characters (Levin, 1970). As another example, Sarbin considered the influence of Sir Walter Scott's *Waverley* novels on plantation owners of the antebellum southern United States. These individuals not only knew of the characters in these novels but adopted their characteristics, even going to the extent of calling themselves the 'Chivalry' (see also Fulford, 1999).

In the same way, the published and dramatized narrative accounts of specific illnesses have entered into popular consciousness. Plummer (1995), in his analysis of the role of published sexual narratives in shaping popular consciousness, wrote:

Without lesbian and gay stories the lesbian and gay movement may not have flourished. Without the stories told by abuse survivors, the whole rape movement would probably have floundered. (p. 145)

These written accounts are readily available in bookstores and are read eagerly by patients and their family members. Of course, as Fulford (1999) stressed recently, 'in narrative the centre of gravity long ago shifted to films and TV—and there captured the high ground and seized the vast territory of the imagination that was once commanded by the authors' (p. 151). Thus, an important component of the ideological level of analysis is a detailed study of media representations of illness (see Lyons, 2000). In

our study of social representations of cancer (Murray & McMillan, 1988) it was apparent that narrative accounts of particular television characters had entered into popular local consciousness.

Integrating levels

While narratives may be analysed as personal attempts to make sense of disruptions in individual biographies, they can also be analysed as social performances. Doise (1986) argued that the key challenge facing social psychology is the articulation of levels of analysis. By this he meant that the challenge is to connect explanations across the different levels of analysis. In our case, the challenge is to connect the different levels of narrative analysis within health psychology. The narrator tells his or her illness story to someone who may be real or imagined and he or she also tells it within a certain sociohistorical context. The narrator is neither a pawn nor is he or she a sole agent. There exists a dialectical interplay between the storyteller and his or her world. Karl Marx (1852/1968) described this process well in his famous maxim:

Men make their own history but they do not make it as they please; they do not make it under circumstances chosen by themselves, but under circumstances directly encountered, given and transmitted from the past. The traditions of old dead generations weigh like

a nightmare on the brain of the living. (p. 96)

In telling his or her story the narrator makes use of this socially embedded language. It is not fully the narrator's story: its structure is conditioned by both the immediate presence of others and the dominant plot lines in society. Researchers often focus on one level of analysis to the neglect of the other. The challenge is to articulate the telling of illness narratives across these different levels.

Gubrium and Holstein (1998), using a framework in many ways similar to that of Doise, point to the central role of what they term 'narrative practice' in integrating human experience. They define narrative practice as the activities of storytelling that simultaneously characterize 'the resources used to tell stories and the auspices under which stories are told' (p. 164). The resources can be compared to the broader social memories, social frames or social representations together with the personal experiences of the storyteller and the locally available discursive formations. These resources fall largely within the ideological level of analysis. The auspices are defined as 'the discursive mandates and constraints that characterize a particular setting' (p. 164) and would fall within the interpersonal and positional levels of analysis. Placing the storyteller at centre stage, Gubrium and Hosltein argue that the storyteller constantly edits his or her story. He or she is not determined by

either the resources or the auspices but 'constantly monitors, manages, modifies and revises the emergent story' (p. 170). The narrator may be at centre stage but he or she cannot extricate him- or herself from the broader soup of social interaction. While they can contribute to that soup, they are also shaped by it. This raises many questions about combating particular master narratives.

An example of articulating different levels of narrative analysis of illness is the study by Gay Becker (1997) on the impact of suffering in people's lives. She argued that an important component of the western conception of the self is the sense of continuity and coherence. Illness or any traumatic event disrupts this continuity while narrative provides a means of restoring coherence. Becker suggests that 'the strength of the ideal of continuity and its pervasiveness suggest that in the United States disruption to life may seem all the more abrupt because of the tendency to view life as a predictable, continuous flow' (p. 7). Becker suggests that in cultures where sensation and bodily expression are valued we can have direct access to the illness experience. In western society, she argues 'narrative is our primary means of accessing the bodily experience and is essential to our understanding of that experience' (1997, p. 26). Thus, she is arguing from the ideological level of analysis through to the intrapersonal level.

Howard Waitzkin and his colleagues (Waitzkin, Britt, & Williams, 1994) illustrated how within the clinical encounter certain ideological assumptions shaped the character of the patient's narrative account through discouraging reference to the social and contextual aspects of the illness. They argued that:

In these ways, the discourse maintains ideological assumptions that value individualism and stoical attempts to cope with adversity. Critical exploration of alternative arrangements to enhance her social support does not occur. After the medical encounter, the patient returns to the same contextual problems that trouble her, consenting to social conditions that confront the elderly in this society. (p. 336)

It is important to reemphasize that these levels of analysis are just that: levels of analysis. In reviewing the various studies of narrative accounts of illness it was apparent that researchers deliberately connected across these different levels in attempting to understand human experience. Admittedly the recent debate between Billig (1999) and Schegloff (1999) would indicate that some researchers would prefer to work at one level of analysis. For a critical health psychology the challenge is to move beyond the dominant personal level of analysis to

consider more social processes. This returns us to Frank's (1998) original question. In attempting to grasp the authorship of personal narratives of illness he argued for a combination of Foucault's archeological approach which stressed the importance of ideological factors with a more humanist approach which considered the personal value of the narrative account. In terms of this article, he was articulating the ideological and personal levels of analysis. In the same way Ricoeur argued that while 'we learn to become the narrator of our own story' we do so 'without becoming the author of our life' (Ricoeur, 1987, p. 437).

Narratives of change

In closing it is useful to consider that while telling one's story holds out the prospect of caring for the self (cf. Frank, 1998), to do so may require a challenge to the dominant storyline. For the individual storyteller this can be a difficult task and can lead to doubts and anxieties. The public declaration of one's story can be described as a call for support from others. It is not simply a giving witness, but a search for validation. The last decade and more have seen a coming together of patient groups that provide an opportunity for such processes of validation and the development of coherent stories of resistance. This process is described vividly by Plummer (1995) in the case of sexual stories and by Kaufert (1998) in the case of breast cancer stories.

White and Epston (1990) have explored the clinical implications of a clash between the dominant cultural narrative and the lived experience of people. The role of narrative therapy is to undermine the dominant narrative that makes certain experiences problematic and to develop a new story that enhances alternative knowledge. While much of the work in narrative therapy has been directed at the clinical encounter, health psychologists have an important role in the wider community as people who can challenge the adequacy of dominant public narratives and assist in the development of alternative more critical narratives. From this perspective, narratives are not simply a personal means of self-care but an opportunity to engage with others to critique the adequacy of master narratives within official discourse.

In discussing the role of narrative in socially shared belief systems it is important to consider their ideological dimensions. This is a crucial task which a critically informed health psychology needs to tackle. Van Dijk (1998) suggests that ideologies can be considered the basic axioms of social representations. However, it is insufficient to discuss ideology without including reference to the power bases of such axioms and how they can be challenged. Mikhail Bakhtin (1981) referred to the centripetal forces which pull everyday language towards the dominant discourse such that it is difficult to resist. He suggested that one way we

could resist this was through buffoonery and parody. This would suggest that one way the narrator can challenge the official story of illness is through humour and mockery. Health psychology has an important role to play in developing these and other subversive strategies which not only undermine the official narratives but also provide support for counter-narratives.

Work by Rappaport and his colleagues (Rappaport, 1993; Thomas & Rappaport, 1996) have shown one strategy of combating master narratives which builds on the ideas of Bakhtin. They argue for the central role of arts and drama as a means of developing a counter-narrative. Through participation in such activities, health psychologists move from being observers to promoters of change (see Gray, in press). In beginning to challenge the master narratives, health psychologists can begin to understand the power structures that maintain them and the strategies needed to change them. Simultaneously, the process of assisting with developing counter-narratives can be a means of strengthening the confidence of the marginalized and underprivileged. Participating in the development of such counter-narratives requires going beyond the supposed impartiality of positivist science. As such, narrative theory can assist in the development of a more activist and critical health psychology.

CHAPTER 5

CONNECTING NARRATIVE AND SOCIAL REPRESENTATION THEORY IN HEALTH RESEARCH

Introduction

According to narrative theory, human beings are natural story-tellers, and investigating the character of the stories people tell can help us better understand not only the particular events described but also the character of the story-teller and of the social context within which the stories are constructed. Much of the research on the character of narratives has focused on their internal structure and has not sufficiently considered their social nature. There has been limited attempt to connect narrative with social representation theory. This article explores further the theoretical connections between narratives and social representations in health research. It is argued that, through the telling of narratives, a community is engaged in the process of creating a social representation while at the same time drawing upon a broader collective representation. The article begins by reviewing some of the common origins of the two approaches and then moves to consider a number of empirical studies of popular views of health and illness that illustrate the interconnections between the two approaches. It concludes that narratives are intimately involved in the organization of social representations.

The past 20 years have seen increasing interest in the study of narrative throughout the social sciences. Within psychology this has resulted in the development of a so-called narrative psychology (Murray, 1997a, 1997b; Sarbin, 1986). According to narrative psychology, a central defining characteristic of human beings is our story-creating and story-telling nature. We are all story creators and tellers. Narrative is a human means of organizing our interpretations of reality. The basic function of narrative is to provide meaning to events we encounter in our everyday lives. Paul Ricoeur (1984) argues that one of the central dilemmas in conceptualizing how we make sense of the world is its changeability. Even as we attempt to assert some order, the world continues to change. By creating narratives, humans can organize and give meaning to the ceaseless flow of events. It is a central means of grasping time. As Ricoeur explained: "by telling stories and writing history we provide 'shape' to what remains chaotic, obscure, and mute" (1991a: 115). When there is some disturbance in our lives, we can bring order to it by placing it within a narrative.

Social representation theory is concerned with understanding everyday common sense (Moscovici,

1984a). In many ways it is similar to narrative psychology in that it is concerned with the popular means of making sense of the world. Surprisingly there have been few attempts to look at the connections between these two theoretical approaches (see Flick, 1995; Laszlo, 1997). In this article I argue that there are many potential connections and an exploration of these connections can enrich both theories. I begin by summarizing the complementary origins of these two theoretical approaches and explore how the theories have conceptualized different ways of thinking. I then consider the content and narrative structure of social representations and the role of time in both theories. I finish by considering their different levels of analysis and their differing approaches to the study of identity. I draw particularly upon the theoretical work of Paul Ricoeur and Serge Moscovici, and the empirical work on health by Herzlich (1973) and others (e.g. Murray, 1997b). My aim is to advance our understanding of the organization and operation of social representations of health and illness (see also Murray, 1993).

Origins

There has always been a tension in the study of narrative between those who conceived of narrative as a social phenomenon and those who considered it a more individual phenomenon. As a social phenomenon the study of narrative

has a lengthy history in modern psychology. We can trace this social approach back at least to Wilhelm Wundt, who, in his *Volkerpsychologie* (1900-20), considered the importance of such narrative phenomena as myths and legends in everyday life. Randall has defined myth as "a story that is larger than life, that is ancient and archetypal and deeply rooted in the human condition, yet within which our own individual story is conceivably cradled" (1995: 10). Farr (1996) has done much to show the link between Wundt's *Volkerpsychologie* and Thomas's study of social attitudes in the early 1900s. In their study of the experience of Polish immigration to the United States in the early years of the 20th century, Thomas and his colleague Znaniecki (1918-20) developed a particular narrative approach to social research. Among the range of methods they used, they explored letters and extensive personal accounts to develop an understanding of the experience of immigration.

This interest in narrative accounts was also apparent in some of the early work by Gordon Allport. During the 1930s, Allport led a project that examined the life histories of refugees from Nazi Germany (Allport et al., 1941). Subsequently, he prepared a report on the use of personal documents in psychological research, in the preface to which he wrote:

A decade of depression, war and misery has had one benign effect. It has brought out upon

the central stage the struggles of the common man, the picture of his daily life, all his homely values. It has brought the documentary film into popularity, the opinion poll ... autobiographies that give unaccented accounts of ordinary experience. (Allport, 1942)

Thomas and Allport were both interested in the use of narrative accounts as a means of exploring personal reaction to a dramatic change in the world of certain individuals. However, they were not concerned with the narrative structure of either the personal accounts obtained or with the historical-cultural context within which they were nested.

Social representation theory can also trace its origins to the work of Wilhelm Wundt. According to Farr, Wundt's *Volkerpsychologie* was particularly concerned with the study of collective representations: "those mental products which 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" (1985: 35). However, it was largely from Durkheim that Moscovici drew his initial inspiration in developing social representation theory. Durkheim distinguished between individual and collective representations. The former, he argued, were the concern of psychologists, whereas the latter were the concern of sociologists. However, he

tended to conceive of these phenomena as static and independent. Markova explained this deficiency in Durkheim's formulation: "it was the inability to master the concept of dialectical interdependence, or co-construction, that made Durkheim's representations so static" (Moscovici and Markova, 1998: 399). Moscovici introduced social representation theory as a deliberately dynamic social psychological phenomenon that connects the individual with the social. Social representations are not simply given, they are created and re-created in everyday social interaction.

Moscovici developed social representation theory in a similar historical moment to that in which Allport and his colleagues were exploring popular narrative accounts. It was the period when many social scientists were questioning the character of everyday thinking and how it connects with scientific and political ideology. Moving to Paris after the Second World War, Moscovici recalled that there was "not much social psychology". It was his wartime experiences that made him "wonder about the impact of science on ordinary culture, how it changes the minds and behaviour of people, how it becomes part of our belief system, and so on" (1998: 375).

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Moscovici felt that, whereas Marxist, or more precisely Leninist, thought was mistrustful of the "spontaneous knowledge" of ordinary people, he "wanted to rehabilitate common knowledge which is grounded in our language and in daily life" (1998: 376). After the horrors of fascism many social psychologists were keen to explore the psychology of the ordinary person. Although Moscovici was formally interested in "spontaneous knowledge", he was particularly concerned with how scientific concepts were integrated into everyday thought and not with the narrative content and structure of popular thinking.

An important linkage between the two theoretical approaches is the work of Frederick Bartlett (1932), who, in his famous study of the role of social processes in remembering, used an experimental procedure that involved the transmission of narrative accounts between people. He found

that the story changed substantially in the transmission. Farr (1998) has argued that this was evidence of the role of culture or collective representations in remembering, but that, although Moscovici drew upon Bartlett in developing his theory of social representations, he did not sufficiently consider the role of culture. Nor did he consider the role of narrative.

Currently there is substantial renewed interest in popular understanding of everyday phenomena such as health and illness. This is both a mass phenomenon and a research interest. The mass interest is reflected in the widespread popularity of memoirs and autobiographies, especially the personal accounts of health, illness and trauma that reflect the ongoing challenge to the broader meta-narratives which have acted as a moral guide to our society (see Murray, 1997b). The research interest is reflected in the rapid growth of investigation into lay accounts of health and illness within the various social sciences. This widespread fascination with popular narrative accounts provides an opportunity to explore the social dimensions of narrative and the narrative dimensions of social representations of health and illness.

Ways of thinking

One of Gordon Allport's original research assistants was Jerome

Bruner, who became a leading advocate of the narrative turn within psychology. Bruner has argued that there are two ways of knowing, the paradigmatic and the narrative, each distinct and "irreducible to one another" (1986: 11). The former is based upon the process of classifying and categorizing that is preferred by the natural sciences. It tries to "fulfill the ideal of a formal, mathematical system of description and explanation" (1986: 12). The alternative, narrative, form of knowing is a popular means of making sense of the world by connecting events over time through stories. This narrative mode is the dominant process of thinking within what Bruner termed "folk psychology", mirroring Wundt's earlier term.

One of the central features of this narrative knowing is that it "specialises in the forging of links between the exceptional and the ordinary" (Bruner, 1990: 47). It provides a means of integrating the strange and unknown into the realm of everyday life. "The function of the story is to find an intentional state that mitigates or at least makes comprehensible a deviation from a canonical cultural pattern" (1990: 49-50). This argument challenges the dominant atomistic trend within much of cognitive psychology and indeed in some contemporary forms of discursive research, which attempts to break human thoughts and discourse down into their

smallest parts. Instead, according to Bruner, "people do not deal with the world event by event or with text sentence by sentence. They frame events and sentences in larger structures" (1990: 64). We do not describe our worlds as a series of bits and pieces, but in narrative forms, some more coherent than others. Thus narrative is not something of interest only to literary researchers, it is also of central importance in understanding everyday life.

In many ways Bruner's twofold characterization of thinking is very similar to Moscovici's conceptualization. As the latter argued:

a radical divergence between two worlds of knowing or acquiring knowledge, the standard and the non-standard one. Several labels have been used to describe it - logic and myth; "domestic" and "savage" thought (Levi-Strauss, 1962); "logical" and "pre-logical" mentality (Levy-Bruhl, 1922); "critical" and "automatic" thought (Moscovici, 1981, 1983) but the nature of these opposites remain the same. (Moscovici and Hewstone, 1983: 102)

Admittedly this dichotomy is not clear cut, which is why Moscovici has referred to the layperson as an "amateur scientist". As a consequence of this concern with science, Moscovici preferred to consider the structure of social representations not in narrative but in logical or categorical terms. For example, he described them as a set

of concepts, statements and explanations originating in daily life in the course of inter-individual communications. They are the equivalent in our society of the myths and belief systems in traditional societies; they might even be said [to be] the contemporary version of common sense. (Moscovici, 1981: 181)

There is a tendency in Moscovici's conceptualization to consign narrative forms to traditional societies, while social representations are portrayed as more logical and typical of modern societies. Indeed he uses terms similar to Bruner's to describe social representations as "kinds of paradigm beliefs" (Moscovici and Markova, 1998: 398). This characterization of common sense in categorical terms is a pervasive theme in much social representation research. However, closer examination of health research projects reveals an implicit narrative organization within the categorical structure of social representations and that these interact with personal narrative accounts.

Content and structure

Much of the research on social representations has focussed on revealing the categorical structure of their content. The innovative initial work on social representations of health and illness conducted by Claudine Herzlich (1973) in the late 1960s is a prime example. It closely followed the classic work by Moscovici on social representations of psychoanalysis, on which Herzlich

was an important collaborator. Herzlich's study was based upon open-ended interviews with a large sample of professional workers and a smaller sample of rural workers. From her interviews, Herzlich classified popular views of illness into three categories: illness as destructive, illness as a liberator, and illness as an occupation.

In his commentary on this study, Janos Laszlo noted that, although Herzlich used ethnographic interviews to collect information from her participants, she deliberately neglected the narrative quality of the interview material. Laszlo noted that: "Instead of also taking into account the storied nature of the explanations, [she] concentrated exclusively on the categorical anchoring and objectification of health" (1997: 163).

We could go further and argue that, both at the stage of data collection and at the stage of data analysis, Herzlich did not consider narrative content and structure, at least not explicitly. A similar criticism has been made by Eliot Mishler and other commentators of contemporary qualitative researchers. For example, Mishler has noted:

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 research questions; and

stories that make it through these barriers are discarded at stages of coding and analysis. (1986: 106)

While this may be the case, an analysis of the categorical coding scheme developed by Herzlich shows many similarities to the typical narrative structures suggested by other researchers and the structure of narrative accounts presented in other research. For example, consider the three standard narrative structures proposed by Ken Gergen and Mary Gergen (1986):

progressive narrative, in which progress towards the achievement of a particular goal state is enhanced;
regressive narrative, in which progress is impeded;

stable narrative, in which no change occurs. (p.)

According to the Gergens, this classification is sufficient to describe the main dimensions of the dominant Western narratives of comedy, romance and tragedy (Frye, 1957). Further, they suggest that this scheme can be used to describe the structure not only of popular but also of scientific narratives. If we compare this narrative structure with the categories proposed by Herzlich, we see certain similarities (see Figure 1). In addition, if we review the empirical material Herzlich provided for her three categories we find that they are abbreviated narratives.

The "illness as destructive" category contains the idea of a regres-

sive narrative in which the opportunity for personal progress is impeded or blocked by illness. In her report, Herzlich includes a number of abbreviated accounts that encapsulate this regressive narrative. For example, she details the tale of a man who has been immobilized for life following an accident and quotes him:

For me, who am forcibly compelled to do nothing, the most painful thing is to see others working and not to be able to do so too ... because I've worked all my life since I was young and now ... it's rather hard to bear, not being able to do anything. (1973: 105)

The "illness as an occupation" category contains the idea of the stable narrative whereby the sick person has to work at the process of recovery. Again, Herzlich gives a number of abbreviated narrative examples of this category. For example, she quotes a young woman who had a friend who was an invalid: "She suffered, she was a martyr ... but you know, there was a whole kind of relationship based on that, an impression of something achieved, of an exchange" (1973: 117).

Finally, the "illness as a liberator" category contains the progressive narrative whereby the person is enhanced by the illness. Herzlich gives a number of abbreviated narratives to illustrate this category. For example, one participant recalled: "You really fight;

I fought like a lion; you've no idea how much energy it takes" (1973: 119).

Thus it would seem that the participants in Herzlich's work were keen to provide narrative accounts, which she then organized into three broad categories. However, Herzlich emphasized that she was not simply summarizing what her participants had to say but connecting their accounts to the broader social expectations, viz.:

Our analysis does not involve the actual behaviour of the individual but the norms which he reveals and his interpretation of them; we are not concerned with the real relations of social exclusion or participation but with the conceptions of these relations which are expressed. (1973: 105)

While Herzlich developed her categories with reference to society's normative expectations, these in turn are enmeshed within a society's broader cultural narratives. In narrative terms Herzlich could be described as exploring the cultural narratives against which the personal narratives were being developed. For example, she describes the "illness as a liberator" within a cultural-religious narrative that normalizes release from work obligations and offers instead an opportunity for almost spiritual development. She details how one of her participants describes the pleasantness of the experience: "I felt as if I were discovering another world,

because there was a kind of pleasantness about my life which was quite exceptional ... I had a world apart from myself, something which, in fact, I needed" (1973: 114).

Conversely, in Williams's (1990) study of the health beliefs of elderly Protestants in Aberdeen, Scotland, there was less evidence of this liberator dimension, indicating the dominance within the Protestant cultural narrative of the value of work.

Other empirical research has produced similar findings. In a three-part study of social representations and narrative accounts of cancer, I conducted interviews with healthy people about how they conceptualized the disease (Murray and McMillan, 1989) and with former cancer patients who described their experience of the disease (Murray, in press), and finally I conducted a detailed analysis of published accounts of the experience of cancer (see Murray, 1997b). In the first study the emergent threefold social representation of cancer was similar to that identified in Herzlich's study. The "cancer as destruction" dimension centred on narrative accounts of suffering and death. The healthy interviewees often made reference to particular individuals who had died of cancer. Thus the disease was personified in the narratives about certain individuals. Indeed, certain media figures took on almost an iconic status. The "cancer as occupation" dimension included

narrative accounts of cancer patients fighting the disease. This characterization is the heroic narrative that has been popularized through alternative health care, but which also pervades much medical care. Individuals who had survived cancer were identified as fighters. Even those who died from the disease were recalled as having fought it, but as having eventually succumbed. The "cancer as liberation" dimension included narrative accounts about the opportunities for re-birth and re-definition of one's responsibilities. There were few such accounts. Behind the individual narrative accounts of cancer was a broader cultural narrative that viewed illness not as an object, but as a socio-moral phenomenon the source of which may be unclear but which could be challenged, to an extent. The lay people in their accounts were not describing cancer in categorical terms, but injecting intentionality and narrative order into their conceptualizations of the disease (cf. Bruner, 1990).

When we interviewed people who had had the disease, their narrative accounts interconnected with these social representations. There were those people who perceived it as the end of their lives. This was particularly so for those who were young and had substantial social responsibilities. The patient had expected life to continue and thus felt frustrated and cheated. A large number of the survivors described their attempts to fight cancer. Although this

meshed with the cultural narrative of a need to morally combat evil, it became a contested narrative when the patients reflected upon the implication that those who did not fight the disease were responsible for their deterioration. Finally, there were those who perceived cancer as an opportunity for re-birth, which concurred with the broad social narrative that achievement in life was a consequence of overcoming adversity. This connected with the broader cultural-religious narrative of enlightenment through suffering. Again, this was a contested story. On the one hand were those who argued that it provided them with an opportunity to deepen their religious faith, while there were others who were aware of this version but did not accept it. This would suggest that the broader cultural-religious narrative was being challenged.

Figure 1 summarizes the argument that the content of the social representations of illness can be organized into certain standard narrative structures. The character of these personal narratives is played out against a broader cultural narrative. In turn, the narrative structures imply a certain temporal dimension.

A common underlying feature of narrative accounts is their concern with time. This is a dimension that has been underdeveloped in social representation theory. Conversely, in narrative theory it is of central importance. Paul Ricoeur argues that we live in a sea of time. Narrative

provides a map of that sea, as it were = it brings order to disorder. A central feature of this narrative process is emplotment, whereby we derive "a configuration from a

succession" (Ricoeur, 1991c: 427). The narrative interpretation of our reality is central; without it we continue to be awash in a sea of time.

Fig 1 Narrative structure of social representations

Gergens	Frye	Herzlich	Murray
Narrative			
Regressive	Literature	Illness	Cancer
Stable	Tragedy	Destruction	Death
Progressive	Comedy	Occupation	Fighting
	Romance	Liberation	Re-birth

Durkheim and several of his contemporaries and colleagues also considered the role of time in human consciousness. The philosopher Henri Bergson felt that we could become aware of the character of the self through focussed inner reflection on the process of time (see Coser, 1992). This contemplative approach initially attracted the interest of the French social psychologist, Maurice Halbwachs. After he began working with Durkheim, he adopted a more social approach. For Durkheim an understanding of time is central to our understanding of social reality. However, for Halbwachs "it was not inner time or duration that was of the essence but rather time as a social construction" (Coser, 1992: 8). As Durkheim wrote in a later work:

"Observation proves that [the] indispensable guide lines, in relation to which all things are temporally located, are taken from social life" (in Coser, 1992: 10). It was this more social view of time, which Halbwachs adopted and developed in his theory of collective memory, that is important in connecting narrative and social representation theories.

According to Durkheim, renewal in the cultural life of societies centres on periods of "collective effervescence". However, he did not consider in detail the character of the social processes that hold society together during periods of calm. For Halbwachs it is a society's collective memories or shared views of its past that give it stability and cohesion. Halbwachs emphasized the socially

active nature of these collective memories that are socially constructed from the present. He noted that:

One is rather astonished when reading psychological treatises that deal with memory to find that people are considered there as isolated beings. These make it appear that to understand our mental operations, we need to stick to individuals first of all, to divide all the bonds which attach individuals to the society of their fellows. Yet it is in society that people normally acquire their memories. It is also in society that they recall, recognise, and localise their memories. (Halbwachs, 1992: 38)

An important feature of collective memory, Halbwachs argued, was that it is developed from the present, viz. "even at the moment of reproducing the past our imagination remains under the influence of the present social milieu" (1992: 49).

Similarly, contemporary narrative theorists emphasize that narratives are composed from the present. For example, the narrative theorist Mark Freeman described the process of remembering as follows:

... one is inevitably remembering selectively, and perhaps conferring meanings on experience that did not possess these meanings at the time of their occurrence ... one will no doubt be weaving these

meanings into a whole pattern, a narrative, perhaps with a plot, designed to make sense of the fabric of the past. (1993: 8)

Implicit in the definition of social representations as "theories" is the idea that we live in a temporal world. Moscovici puts this more explicitly when he argues that:

we mostly live in "virtual" worlds. By this I mean that we live in worlds in part composed of recollections, nostalgias, of things that linger on while they have actually changed. And another part of our worlds consists of anticipations, of probabilities and alternatives that might come to pass in a more or less predictable length of time. (1987: 513)

However, theorists have not explicitly developed the role of time in social representations.

One approach to incorporating the temporal dimension into social representation theory was developed by Flick (1995). He introduced the concept of retrospective anchoring to connect interpretations of contemporary phenomena with those of past events. He suggested that since narratives are concerned with reconstructing past events, they are intimately involved in the process of retrospective anchoring. Since narratives are not just concerned with past events we could also add to this formulation prospective anchoring,

whereby we connect our interpretation of new objects with future events. It is through this process that we confer a futuristic dimension on social representations. For example, we try to make sense of contemporary events by connecting them with futuristic phenomena by reference to science fiction, e.g. the film *Star Wars* in commentary on the recent bombing of the World Trade Center in New York.

In Western society an important component of retrospective anchoring is the linkage with the Judaeo-Christian religious heritage. This heritage intertwines with a cultural tradition that human reality is temporal and storied, and that it has a purpose (see Cupitt, 1990 in Randall, 1995). The theologian Langdon Gilkey has described the temporality of this religious tradition:

God, who is eternal, has created time with a beginning and an end. Time is thus finite, giving to each of its moments the possibility of being unique and unrepeatable. Time is moreover, "going somewhere": from its beginning in creation it moves towards its end or goal, and its moments are meaningful because they lead to this eternal goal. (1965: 302)

In creating contemporary social representations of illness, people draw upon this temporal cultural heritage or collective representation. In our study of women's narrative accounts of the

experience of breast cancer (Murray, 1997b), one feature was the frequent reference to religious narratives. It was through anchoring their experiences in these narratives that the women were able to give their own personal stories some meaning: their illness had a purpose. This was particularly pronounced in those women with a strong religious faith. For example, Georgia Comfort recalled: "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" (1992: 114). This woman continued to connect her experience of cancer to Christ's suffering and her survival from the disease with his resurrection and rebirth. Thus by connecting their illness to this religious narrative, survivors are able to extend their personal narrative, to give it a progressive forward trajectory. These religious narratives influence the very process of story-telling.

Telling stories

Narratives are constructed in a social and interpersonal context. "It is together that we remember; and it is within the social medium of language that we articulate our most individual memories in the mode of narrative" (Ricoeur, 1997: xliii). We share narrative accounts with each other through oral, textual and other representations. Narratives are oriented to the other. The narrator is

attempting to convey the legitimacy of his or her story, to convince the listener.

The order or structure that everyday social interaction demands of narratives exchanged distinguishes them from dreams. One of the particular features of dreams is their lack of structure (Halbwachs, 1992). Dreams are analogous to Ricoeur's pre-narrative experience. This lack of structure provides dreams with a mysterious quality. They contain disconnected sequences of events that melt away when we awake. It is difficult to recall them, whereas recalling stories is straightforward. In providing accounts of experience, we actively organize them in narrative form so that they be easily understood by the other. In addition, they are partly organized for us by the other person and by the culture in which we live.

One of the central features of social representations is their socially dynamic quality. They are created and recreated in everyday social interaction. Indeed, Moscovici has argued that the very use of the term social was meant to indicate that representations are the outcome of an unceasing babble and a permanent dialogue between individuals, a dialogue that is both internal and external, during which individual representations are echoed or complemented. Representations adapt to the flow of interactions between social groups. (1984b: 951)

The recent exchange between exponents of discursive psychology and social representation theory, in the pages of the journal *Culture & Psychology*, has highlighted a certain confusion about the social nature of social representations. Potter and Edwards (1999) accused social representation researchers of avoiding the importance of conversational interaction through "disparaging conversation as 'babble'". They continue: "Conversation thus has the anomalous position of being at the heart of SRT [social representation theory] as the engine for the generation and refinement of representations, and yet being a topic which has received no analytic attention" (1999: 449). Further, they characterize social representations as "cognitive structures or grids".

In a spirited riposte, Markova (2000) argues that Potter and Edwards have misrepresented social representation theory. She accepts that unfortunately some social representation researchers may have unwittingly adopted a fundamentalist epistemology that has led to a more cognitivist view of social representations. This error can be traced to the Cartesian dualism that separates mind from society. Markova prefers a dialectical or dialogical conception of mind that is created in social interaction. Using such a framework, it is apparent that social representations are not cognitive grids but social psychological

phenomena that are created in everyday social interaction. Social representations may be created in that social babble, but what is the underlying character of that process? Potter and Edwards (1999) refer to discourse as the engine of social representations. While this may be so, it neglects the temporal world within which discourse is created. Narrative can be considered a particular form of discourse that attempts to bring order to the unceasing flow of time. In telling a story, the story-teller is aware of the other and is attempting to elicit their sympathy and understanding. In their study of epilepsy narratives, Good and Del Vecchio Good described this process as "draw[ing] [readers] into the diverse perspectives of the characters of the drama, and invit[ing] concern about how the story might turn out" (1994: 838=9). It is through the social process of narration that social representations are created and recreated.

While the interpersonal setting helps shape the character of the narrative told, both are shaped by the broader social representation. Thus in telling his or her story about cancer, the survivor is asserting the extent to which he or she conforms to the standard cultural narrative. For example, Betty Rollins recalled:

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?". (1993: 81)

Through this process of challenge the woman is participating in the wider process of transforming the dominant social representation of cancer. This transformative process also involves a form of identity re-assessment.

Identity

A central concern of narrative theory is identity formation, which is defined as a socially dynamic process. Ricoeur (1991b) termed the process by which the narrative brings structure to the world through various forms of emplotment configuration. Conversely, refiguration is the process by which we define ourselves through narrative. There is a constant interchange between these two processes. In addition, we draw upon cultural plot lines to create our stories about the world and to define ourselves.

Narrative identity does not exist simply at the personal level, but at the community and societal levels as well. Community and societal narratives are the broader social stories the group tells in order to distinguish itself from others. A community narrative can be the

stories about relatives that a family shares. It can be the stories about neighbours that a village shares or it can be the stories about colleagues that a workplace shares. It is how these communities define themselves.

Social representations are also considered the defining characteristic of communities. However, it is the exchange of personal narratives that contributes to the establishment of these social representations. In his study of the development of cultural representations of AIDS in Haiti, Farmer (1994) conducted interviews with residents of Haiti at two points in time. Initially there was limited reference to AIDS, reflecting the limited contact with the disease. However, on the second occasion he found that the residents had lots of stories to tell about AIDS. Farmer argued that this illustrated how it was through the extensive exchange of such stories over time that a shared community representation of the disease developed which was interwoven with the community's own sense of its history.

In our study of social representations of cancer, we conducted interviews with individuals who lived in a particular neighbourhood (Murray and McMillan, 1989). On reviewing these accounts, one common theme that emerged was the recurrence of stories about specific individuals. These individuals included not only those who lived in the immediate locality but also popular media figures who had had

some experience of cancer. Several of the interviewees spoke about an individual who had been treated for cancer, apparently successfully, and then subsequently died of the disease. In these stories the structure became anchored in the personalities of the individual or central character, who was portrayed as tough or weak, adventurous or conservative. This illustrates how media stories about individuals help create a community's representation of the disease.

A societal narrative is more extensive. At the widest level it can encapsulate the history of a people. It is this historical narrative that defines a society. As such, it can be compared with the collective memory described by Halbwachs. Social narratives or myths can be used to anchor new phenomena. In particular, socio-religious stories and myths convey the history of a society. As Sarbin recently argued:

It is through mythic stories that a culture gives expression to its ideology, the basic political and moral imperatives for living. An ideology provides the definitions of human nature, and the justifications and reasons for collective action and belief. Myths hold society together, bind the past, present and future, and provide the outlines for constructing moral codes that define good and evil. Myths provide the foundational subtexts for sacred stories, the moral

messages of which are given ontological status, that is, they are taken for granted, beyond doubt. (1997: 74)

These societal narratives provide shape and content to collective representations.

Socio-historical stories can take on political force such that they assert one dominant interpretation of reality. Edward Said, the post-colonial theorist, described this political dimension of societal narratives in his discussion of the historical power of imperialism:

The main battle in imperialism is over land, of course; but when it came to who owned the land, who had the right to settle and work on it, who kept it going, who won it back, and who now plans its future = these issues were reflected, contested, and even for a time decided in narrative.... [Therefore] the power to narrate or to block other narratives from forming is very important for culture and imperialism, and constitutes one of the main connections between them. (1993: xii=xiii)

Admittedly individuals and groups can, in different ways, challenge such dominant narratives. Indeed, as Rappaport (1993) has argued, it is through community mobilization that communities can begin to challenge repressive narratives and develop more emancipatory ones.

Through developing new collective narratives, societies are engaged in the process of identity transformation.

Social representation theory has considered to a limited degree the issue of political power that can in turn inform our analysis of narratives. For example, Moscovici (1984a) distinguished between three types of social representations:

Hegemonic: this type is shared by a highly structured group and is uniform and coercive. It can be compared with the ideological narrative discussed by Said. It has the power to impose itself on others and to shape wider interpretations for the interests of the dominant group.

Emancipated: this type of social representation has broken away from the interests of a minority social group and become widely accepted. It can be compared to the medical narrative account of illness that has attained widespread legitimacy.

Polemical: this type is generated in the course of political conflict and is determined by antagonistic relations between groups. It can be compared to the counter-narratives developed by minority groups in their attempts to challenge the dominant narratives, e.g. alternative health narratives.

In constructing their narrative accounts of health and illness, people position themselves with reference to the political content of these social representations.

In our study of social representations of cancer, it was apparent that people were aware of alternative narrative structures. For people with the disease, this required that they explicitly challenge certain representations. In particular, they challenged the fighting representation with its associated blame for the loser. In this sense, through their narratives the survivors were challenging a particular social representation that condemned their peers who did not survive. This challenge became particularly explicit in the published accounts of the cancer survivors. Through the process of collective challenge to this dominant representation they began to redefine themselves and to develop a new, shared political identity.

Conclusion

In this article I have explored some connections between narrative and social representation, particularly in health research. These connections can be summarized as follows:

- *Common origins:* both theoretical approaches can trace their origins to a common concern for

understanding everyday thought and language.

- *Popular ways of thinking:* both approaches distinguish between different forms of thinking, although social representation theory has focussed on categorical rather than narrative forms.
- *Content and structure:* a review of empirical work on social representations of health reveals their narrative structure.
- *Concern with time:* both theories are concerned with human conceptualizations of time but, whereas narrative theory has placed this temporal dimension at the centre of its concern, social representation theory has tended to neglect it.
- *Identity:* narrative theory has explored the construction of personal, community and societal identity, while social representation theory is particularly concerned with a community's sense of identity.

Admittedly, these connections have merely been introduced. There is need for a more sustained engagement to explore further the connections between these two theoretical approaches and to develop a more sophisticated understanding of popular views of health and our social reality.

Part II

CHAPTER 6

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. (p.)

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 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. (p.)

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. "Its 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. (p.)

Jerome Bruner (1995) also comments on how the very obscurity 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. (p.)

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, p.).

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-Kulka 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 - indeed the story of the argument cannot be abstracted from that context.

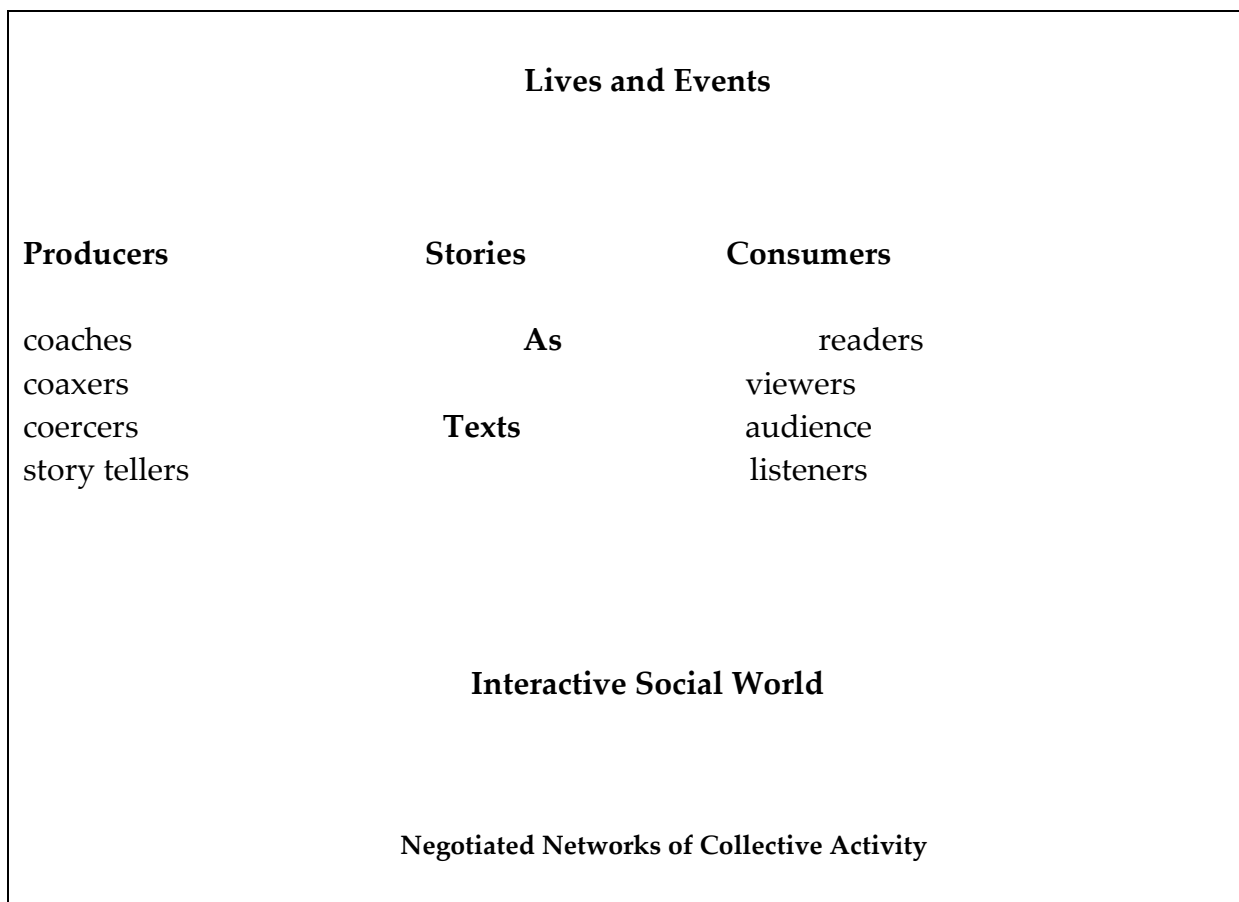
Although the narrator tells the story, the character of the story told will depend upon someone to whom it is told and the tellers relationship with him or her. This issue is raised by Cornwell (1984) in the discussion of her study of the health beliefs and practices of working class people resident 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).

Figure 1 Stories as joint actions



(Adapted from Plummer, 1995)

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

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

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).

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 Cornwall'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. (pp.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 (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) has 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 not 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, "A 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 a limitation but rather an opportunity for change.

CHAPTER 7

ANALYSING NARRATIVE ACCOUNTS

Introduction

Recently, the British writer A.S. Byatt published a collection of essays about narrative in which she argued that narrative lies at the heart of being human. Narration, she claimed, 'is as much part of human nature as breath and the circulation of the blood' (Byatt, 2000: 21). Narrative pervades our everyday life. We are born into a narrative world, live our lives through narrative and afterwards are described in terms of narrative. Until recently, the study of narrative was considered as being of interest only to literary or folklore critics (e.g., Brooks, 1985; Propp, 1968), but it increasingly has assumed greater importance in the social sciences. Narrative is concerned with the human means of making sense of an ever-changing world. It is through narrative that we can bring a sense of order to the seeming disorder in our world, and it is through narrative that we can begin to define ourselves as having some sense of temporal continuity and as being distinct from others. The aim of this chapter is to consider some of the theoretical issues around narrative psychology and some methodological issues around forms of narrative research.

History of Narrative Psychology

Recent interest in the study of narrative arose as part of the general turn to language that occurred in the social sciences in the 1980s. Within psychology, three classic texts marked the specific narrative turn. The first was *Narrative Psychology: The Storied Nature of Human Conduct*, edited by Theodore Sarbin (1986). This collection amounted to a manifesto for the transformation of psychology. Sarbin contrasted the machine metaphor which he argued, underlay much of mainstream psychology with that of the narrative metaphor. He summarized the implications of this alternative model:

In giving accounts of ourselves or of others, we are guided by narrative plots. Whether for formal biographies or autobiographies, for psychotherapy, for self-disclosure, or for entertainment, we do much more than catalog a series of events. Rather, we render the events into a story. (p. 23)

In a later interview with Heaven (1999), Sarbin described how this idea arose in his discussion with

theorists in the humanities. At first, he recalled, he did not distinguish between narrative as a mode of representation and narrative as an ontological form. However, over time, he became convinced that the latter stronger form of narrative was more appropriate. As he emphasized in his interview with Heaven (1999), stories have ontological status. We are always enveloped in stories. The narrative for human beings is analogous to the ocean for fishes. (p. 301)

According to this argument, narratives are not just ways of seeing the world but we actively construct the world through narratives and we also live through the stories told by others and by ourselves – they have ontological status.

The book edited by Sarbin (1986) also contains a chapter by Ken and Mary Gergen (1986) on the structure of narratives which was an extension of an earlier article (Gergen and Gergen, 1984), in which they argued that narratives are social constructions that are developed in everyday social interaction. They are a shared means of making sense of the world. They also have a certain structure. Gergen and Gergen identified three primary structures: which they felt, organized many narratives; that is, the progressive, in which there is movement towards a goal; the regressive, in which the reverse occurs; and the stable, in which there is little change. This analysis is similar to the classic division of

narrative into comedy, romance, tragedy and satire (Frye, 1957). Comedy is a story of progress towards a happy ending, romance is also a progressive tale in which the protagonist overcomes adversity and regains what has been lost, tragedy is more a regressive tale in which the protagonist suffers adversity despite the best of intentions while satire adopts a more stable stance and considers the absurdity of life. Later in this chapter, we will consider the value of this model in the analysis of narrative accounts.

The second important book was *Acts of Meaning* by Jerome Bruner (1990), which followed his earlier *Actual Minds: Possible Worlds* (Bruner, 1986). In these books, Bruner argued that there are two forms of thinking: the paradigmatic and the narrative. The former is the method of science and is based upon classification and categorization. The alternative narrative approach organizes everyday interpretations of the world in storied form. The challenge of contemporary psychology is to understand this everyday form of thinking. Bruner identified a number of defining properties of narrative, including the following:

It is composed of a unique sequence of events, mental states and happenings involving human beings as characters or actors.

It can be 'real' or 'imaginary'.

It specializes in the forging of links between the exceptional and the ordinary.

These properties help us understand narrative as ways of constructing reality, of bringing sense to something that is obscure or unusual.

The third influential book was *Narrative Knowing and the Human Sciences* by Donald Polkinghorne (1988). While this book is wide-ranging in its scope, perhaps one of its most important features was the opening up of hermeneutic philosophy, in particular the work of Paul Ricoeur, to more widespread discussion within psychology. Ricoeur has developed an immense body of work on the centrality of narrative for meaning making. In his classic work *Time and Narrative*, Ricoeur (1984) has argued that since we live in a temporal world we need to create narratives to bring order and meaning to the constantly changing flux. Further, not only do we create narratives about the world but also narrative is central to how we conceive of ourselves, to our identity. It is through narrative that we not only construct a particular connectedness in our actions but also distinguish ourselves from others.

During the 1980s and 1990s, the study of narrative became much more extensive within various fields of psychology. Within personality and human development studies, Dan McAdams (1985) argued that narrative is central to our self-definition:

We are all tellers of tales. We each seek to provide our scattered and often confusing experiences with a sense of coherence by arranging the episodes of our lives into stories. (p. 11)

He also developed an approach to the study of narrative based upon a developmental model. The earliest form is the narrative tone which can be either optimistic or pessimistic. The former is characteristic of comic and romantic narratives whereas the latter is characteristic of tragedy and satire. This is followed by imagery which he described as a “treasure trove of personalized symbols and fantasized objects” (p. 55) that develops as we mature. At a more advanced level is the story theme which is the “recurrent pattern of human intention” (p. 67) and the ideology which is revealed in the values and beliefs underlying the story. Each of these characteristics needs to be considered in investigating narrative.

Within clinical psychology, there was a movement towards the development of a form of narrative therapy (e.g., Mair, 1989; Neimeyer, 1995) that is based upon exploring alternative stories. Within health psychology, several researchers (e.g., Crossley, 1999; Murray, 1997a) argued that narrative is an everyday means of making sense of the disruption of illness. Of particular note, the study of narrative within psychology encouraged the growth of greater

contact with the humanities (e.g., Fulford, 1999; Joy, 1997) and with the other social sciences (e.g., Maines, 1993).

Definition of narrative

According to narrative theory (e.g., Murray, 1999; Sarbin, 1986), we are born into a storied world, and we live our lives through the creation and exchange of narratives. A narrative can be defined as an organized interpretation of a sequence of events. This involves attributing agency to the characters in the narrative and inferring causal links between the events. In the classic formulation, a narrative is an account with three components: a beginning, a middle and an end. Indeed, Bettina Becker (1999) has argued that in our world the number three has a special quality. For example, unlike the open-ended nature of a straight line, a triangle is enclosed, finished. In the same way, a narrative offers an integrated account of an event. Unlike an open-ended piece of discourse, a narrative has a finished structure. The full dimensions of this structure may not be detailed in everyday conversation. Rather, depending upon the context, certain endings may be left unfinished, and it is the job of the audience/reader to complete the narrative. Since we live in a storied world, we can draw upon more established social narratives to explain an event or to complete a particular story. This is not a process of which we are always conscious.

Function of narrative

The primary function of narrative is that it brings order to disorder. In telling a story, the narrator is trying to organize the disorganized and to give it meaning. This is not a straightforward task. As Ricoeur (1987) says:

The narrative ... is a synthesis of the heterogeneous. But concord cannot be without discord. Tragedy is paradigmatic for this: no tragedy is without complications, without fickle fate, without terrible and sad events, without irreparable error committed in ignorance or by mistake rather than through evil-mindedness. If then concord wins out over discord, surely it is the battle between them that makes the story. (p. 436)

The ongoing tension continues as we try to give meaning to the various challenges to the order of our everyday life. Indeed, the tension intrinsic to narrative continues into the analysis of narrative accounts. This is often tentative and open to further challenge.

The use of narrative is particularly pronounced in everyday understandings of disruption (e.g., Becker, 1997). We all encounter disruptions to our everyday routines. Such disruptions include personal problems, family problems, financial problems, and health problems. These challenges to our daily routines

encourage attempts by us to restore some sense of order. Narrative is a primary means of restoring this sense of order.

The classic experiment by Heider and Simmel (1944) is an illustration of what can be described as this human urge to narrative. In that experiment, participants were shown a sequence of pictograms of abstract shapes in different positions. When asked to describe the pictograms, the participants replied with short stories. Since Heider and Simmel were interested in how the participants attributed causal connections, they did not consider the structure of the stories they developed. Fortunately, some of these stories were included in their report of the experiment, and it is apparent that although they were brief, the stories contained the basic elements of the classic narrative with a beginning, middle and an end.

Although we can use narratives to describe the movements of inanimate objects, such as in Heider and Simmel's experiment, it requires that we give those objects agency. Humans are action centres that strive within bounds to create their own worlds. They provide narrative accounts of their experiences that imply their role or lack of role in shaping these events. The converse of agency is suffering (Ricoeur, 1984). When we are denied the opportunity to express our agency, we experience suffering. Accounts of suffering reveal this restraint on our free agency.

Suffering can be due to some personal misfortune, but it can also be due to social oppression that denies the opportunity for true agency.

The need to restore a sense of order following disruption is especially pronounced in Western society, which is bounded by order and rationality. Gaylene Becker (1997) has argued that Western ideas about the life course emphasize linearity. Living in such a world, we try to make sense of inconsistencies. Further, when we try to explain our disruptions to another, we are particularly keen to emphasize our reasonableness.

The central process of bringing order has been termed 'emplotment' by Ricoeur (1984), to denote the organizing of a sequence of events into a plot. This sequence of events can be brief or limitless. We can tell the story of going shopping or the story of the creation of the universe (cf. Polkinghorne, 1996). The common theme is the attempt to give these events a narrative shape. Events do not just happen. In the narrative, there is an interconnected sequence that leads from start to finish. However, the event has ended before the narrator has started to construct a narrative. Freeman (1993) has alerted us to this process:

Consider again the word 'recollection' itself: while the '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. 40)

In telling the story, the narrator is aware of the ending and constructs the account from there. In life, all narratives are provisional; they are subject to change as new information becomes available. It is not that the narrator is trying to mislead the listener but rather, from a more extended perspective, different pieces of information become available for the story.

Narrative identity

Narrative not only brings order and meaning to our everyday life but, reflexively, it also provides structure to our very sense of selfhood. We tell stories about our lives to ourselves and to others. As such, we create a narrative identity. 'Subjects recognize themselves in the stories they tell about themselves' (Ricoeur, 1988: 247). We can hold a variety of narrative identities, each of which is connected to different social relationships. Each narrative identity not only connects us to a set of social relationships but also provides us with a sense of localized coherence and stability. At times of instability, we can make connections to other aspects of our narrative identities.

It is through narrative that we begin to define ourselves, to clarify the continuity in our lives and to convey this to others. We are active agents who recall the actions we have achieved and also those that have been

suppressed by others. Narrative enables us to describe these experiences and to define ourselves. In constructing a personal narrative, we are selecting certain aspects of our lives and connecting them with others. This process enables us to assert that our lives are not a disconnected sequence of events but have a certain order.

This process of narrative identity formation is dynamic and occurs in a changing social and personal context. The values attached to different experiences in that context influence the character of events recalled and thus the shape of the story told. As Ricoeur (1987: 437) emphasized, this indicates 'we learn to become the narrator of our own story without completely becoming the author of our life'. While we can tell our life story, the actual pattern our life takes and indeed the very structure of the story we tell are shaped by a multiplicity of social and psychological forces both conscious and unconscious (Hollway and Jefferson, 2000).

Social dimensions of narrative

Narrative accounts are not emitted in a vacuum; rather, they are encouraged and shaped by a certain social context. Although the narrator tells the story, the character of the story told will depend upon whom the story is being told to, the relationship between the narrator and the audience, and the broader social and cultural context (Murray, 1997a). Thus, the study of

narrative breaks down the traditional psychological/social distinction and develops a more complex psycho-social subject. The narrator is an active agent who is part of a social world. Through narrative, the agent engages with that world. Through narrative analysis, we can begin to understand both the narrators and their worlds.

Although narrative is often considered in individual or personal terms, we can also consider group, community or societal narratives. These are the narratives that particular collectives tell about themselves, their histories and their aspirations. In the same way as personal narratives are involved in the creation and re-creation of personal identities, these social narratives define the history of a collective and distinguish it from other collectives. Further, these collective narratives overlap with personal narratives such that individuals can define themselves as part of the group. In discussing narrative analysis, we should think about the level of analysis we are considering (Murray, 2000). Moreover, in analysing the personal narrative, we should attempt to consider the character of the broader social narrative within which it is being created.

In sum, we are enmeshed in a world of narrative; we understand our world and ourselves through narrative. As such, the study of narrative provides the researcher with a means to understand how we make sense of the world and of ourselves.

The meaning of different narratives is not always apparent and can be approached in different ways by different researchers.

Collecting Narratives

The primary source of material for the narrative researcher is the interview. Unlike the traditional structured interview that has a detailed series of questions to be answered, the narrative interview is designed to provide an opportunity for the participant to give a detailed narrative account of a particular experience. The life-story interview is the most extended version of the personal narrative interview. Gerontologists have particularly favoured this life-story approach as a means of exploring the experience of ageing (e.g., Birren et al., 1996).

As its name implies, the aim of the life-story interview is to encourage the participants to provide an extended account of their lives. The researcher will explain at the outset of the interview that the aim of the study is to learn about the person's life. While this may seem a simple invitation, the participant may, in practice, often be wary and uncommunicative at the outset. It is for this reason that the interviewer may need to meet with some participants on a number of occasions to win their confidence and to encourage them to reflect on their life experiences.

However, narratives are not just life stories in the most general sense but also stories about everyday experiences, especially disruptions of daily life. We can in the interview setting encourage participants to tell stories about particular experiences of change or disruptive episodes in their lives. Flick (2002) has termed this approach the episodic interview. Given the time and the opportunity, participants are often very willing to provide extended narrative accounts of different experiences. See Box 6.1 for examples of interview guides. It is obvious from these that the researcher has a particular focus for the interview but provides lots of latitude for the participant to develop the narrative account.

Box 6.1 Sample interview guides

1. I would like you to tell me about yourself – where you were born, where you grew up, that sort of thing. You should not be in any way inhibited about what to say, but just tell me as much as possible about yourself.
2. I am interested in finding out what happened during the selection interview. You can begin at the time you left home for the meeting and just tell me as much as you can remember.

A challenge for researchers is to convince the participants that they are

interested in their narrative accounts but at the same time present a neutral stance so as not to encourage a particular narrative. Thus, the researcher should give encouraging nods and remarks but refrain from overt commentary since this may disturb the narrative. At the close of the interview the researcher may review reflect upon what the participant's narrative are saying and introduce supplementary questions designed to obtain clarification, such as 'Why do you think that is the case?' or 'Could you give an example of that?' It is preferable to keep comment to the end of the interview when the participant's narrative account is reviewed (see Jovchelovitch and Bauer, 2000).

Sometimes it may be useful to invite participants to a group meeting where they can share in the telling of stories about an event. This focus group approach provides some participants with a greater sense of control and confidence (see Chapter 9 of this volume; also Wilkinson, 1998a; 1998b). These group interviews can be followed or supplemented with individual interviews. Another approach is for the researcher to provide the participant with a written list of the key issues details of the issue to be discussed. This helps to alleviate any suspicions the participant might have that there are some trick questions to come.

The interviewer can also use other methods such as encouraging

the participants to keep a personal journal or to collect photographs or even to make a video. The aim is always to find a technique with which the participants are comfortable and which will allow them to develop their narrative account. Further, the researcher can analyse narrative material that is already available. For example, you can analyse published memoirs or films (e.g., Murray, 1997b; Loizos, 2000).

Since stories develop out of a particular social context and are told to a certain audience, it is important that such details are recorded when collecting narrative accounts. Mishler (1986) noted with reference to the importance of considering the interview setting:

The interviewer's presence and form of involvement – how she or he listens, attends, encourages, interrupts, digresses, initiates topics, and terminates responses – is integral to a respondent's account. It is in this specific sense that a 'story' is a joint production. (p. 82)

The researcher should collect background material about the central participants as well as details about the interviewer. Such information is important when we begin to analyse the narrative accounts.

A useful strategy is for the researcher to keep a detailed log of each interview. This could include some basic demographic details of the

participant and when and where the interview occurred. Sometimes after the interview has ended and the tape recorder has been switched off, the participant will make some additional comments that can substantially influence the interpretation of the whole narrative. It is important that the researcher pay careful attention. After the interview has ended, the researchers should record in their logs as much detail and commentary as they can recall about the interview. Even at this early stage the researcher should be considering what the key issues arising are and how the narrative is structured.

Some logistical issues

It is important that care be taken in setting up the interview. The researcher should make some initial contact with the participants, explain the purpose of the study and obtain their consent. At this stage, they can discuss when it would be most convenient to return for a more extended interview and clarify where would be the most comfortable setting. Sometimes the participants are happy to be interviewed at home; other times they prefer to attend the researcher's office or another setting. It is important to remember that it is the participants' choice and to accommodate their preferences as much as possible.

The researcher should practice using a tape recorder and test the quality of the recording. Sometimes

the quality can be poor because of noise outside the interview room or the participants' speaking quietly. For these reasons, it is advisable to use an external microphone. If possible, the researcher should also attempt to ensure that the power is not interrupted during the interview by connecting the tape recorder to the electricity supply or by ensuring that extra batteries are available. It is a sign of respect to the participant for the researcher to ensure that the narrative is carefully recorded. Make sure to use the best available recording equipment and check that it works. Finding that the batteries fail halfway through the interview or discovering afterwards that the microphone did not pick up the participant's voice can be very frustrating.

Often the novice interviewer will be apprehensive about using a tape recorder and think that this will inhibit the participant. Fortunately, the reverse is often the case. After the researcher has carefully explained the study and assured the participant of confidentiality, the participant is often very enthusiastic. Sometimes after an initial hesitation, the participants will proceed to talk at length about their various experiences. The very fact that they have an audience for the story can act as a spur to more sustained reflection. It is surprising that even when the interview is being videotaped and requires additional technical personnel, many people, once they have agreed to participate,

will be only too generous with their time and will be surprisingly frank and revealing. It is for this reason that the researcher should treat the participant with the utmost respect and courtesy. In addition, if the participant becomes distressed, the researcher should be prepared to stop the interview and, if necessary, ensure the participant is aware of appropriate support services.

Afterwards, it is important that the interview be transcribed carefully. It is a great advantage to have a professional transcriber, but this does not mean that the researcher does not have a role to play in the transcription process. Rather, the researcher should carefully review the transcript with the tape recording, correcting any errors in the transcription. This should be done as soon as possible after the interview, since it is easy to forget what the person had to say, especially when interviewing a number of people.

There are different ways of preparing interview transcripts for analysis. This depends upon the analytic frame preferred by the researcher (cf. Chapter 7). In narrative analysis, the focus is on getting the main narrative account. The narrative transcription should include, where possible, exclamations, pauses and emphases. You can underline certain parts of the text that the participants have stressed in their speech or add notes to mark such paralinguistics as sighs. The aim is to convey the detail

and tenor of the story or stories. The transcription should also include the words of the researcher such that the character of the conversational exchange is apparent. We will see this more clearly in the example given below.

Analysing narratives

The analysis of narrative accounts can be divided into two broad phases – the first descriptive and the second interpretive. A thorough reading of the transcribed narrative precedes both phases. In reading the narrative accounts, the aim is to familiarize oneself with both their structure and their content. A useful strategy is to prepare a short summary of the narratives that will identify the key features, such as the beginning, the middle and the end. The analysts can highlight key issues in the text and identify narrative linkages that connect different parts. They can also discern sub-plots within the broader narrative and consider connections between these. The summary will highlight the particular features in which the researcher is interested. In reading across the summaries, it is then possible to begin to get an idea of what the main issues being raised are (Mishler, 1986). It is through this process of close reading that a coding frame can be developed that can be applied to the various narratives. This coding frame is designed to capture the overall meaning of the narratives

and the various particular issues raised within each.

The second step is to connect the narrative with the broader theoretical literature that is being used to interpret the story. Thus, the researcher goes beyond the descriptive phase to develop the interpretation. This requires a simultaneous familiarity with the narrative accounts and with the relevant literature such that the one can begin to connect with the other. This phase of the analysis can lead to labelling certain accounts as being of a certain type that illustrates their theoretical content. For example, we might be interested in how certain people handle particular crises in their lives. In the reading of the narratives, the central concern is how the narrators describe the various crises in their lives, how they draw on particular sources of support, and how they orient the story to the listener. Each story is examined for particular narrative elements – how the elements in the narrative are linked together (the structure and tone), what issues are the main themes, emphasized and what images and metaphors are used, and what are the underlying beliefs and values.

Role of the reader

The process of narrative analysis is not a passive process. Rather, the researchers bring to the text certain assumptions and beliefs that they use to analyse the narrative. In discussing

the process of reading a text, Ricoeur (1987) makes the same point:

The meaning or the significance of a story wells up from the intersection of the world of the text and the world of the reader. (p. 430)

Ricoeur (1991a) used the term 'appropriation' to describe the process of narrative interpretation. He defined this process as making one's own what has been alien. This is not a one-way process. Not only does the researcher bring to the narrative certain ideas but also, simultaneously, the narrator is trying to convince the audience of the character of his or her story. As Ricoeur (1991a) stresses:

We play with a project, with an idea, we can equally be played. What is essential is the 'to and fro' (Hin und Her) of play. Play is thereby close to dance, which is a movement that carries away the dancer. (p. 90)

Thus, rather than imposing a framework and rather than simply describing the narrative account, narrative analysis requires that the analyst play with the account. In conducting the narrative analysis, it is important to be aware of what theoretical assumptions are guiding the analysis while at the same time being open to new ideas and challenges.

Narrative structure and content

A particular concern in narrative analysis is how the narrative is

structured or organized. Various schemes have been developed to convey the temporal quality of narratives. The threefold classification scheme developed by Gergen and Gergen (1984) is a useful analytic tool, but it is important not to apply it in a schematic way but rather in a flexible manner so as to encapsulate the various shifts in any narrative account. For example, the tragic narrative begins with a progressive structure, but then, despite struggle, the central character is overcome and the narrative becomes regressive. This regression can be overcome by changing the broad interpretive dimensions that are being used to frame the event. For example, people who are upwardly mobile in their career will probably present a progressive career narrative. However, if they are dismissed from their jobs they may develop a more regressive narrative unless they can redefine their goals and so continue to present a progressive narrative. This redefinition of goals, this turning point in a narrative, is similar to an epiphany. This is the moment in the account when the narrator sees the world in a different way. Conversely, a comedy is when a regressive narrative is transformed into a progressive narrative, as narrators redefine their values and realize the positive features of the changed life.

In his analysis of the personal narratives of people with multiple sclerosis (MS), Robinson (1990) used

this temporal scheme. He found that the MS narratives could be organized into the three broad categories. There were those who thought that their lives were ended due to the onset of MS (regressive narrative), those who thought that life had changed but was ongoing (stable narrative) and those who thought that the disease provided new opportunities (progressive narrative).

As mentioned earlier, this concern with narrative structure is similar to the concept of narrative tone that McAdams (1993) and Crossley (2001) place at the centre of narrative analysis. Whereas the structure is concerned with the major components of the narrative and how they are connected the tone is concerned with the overall emotional flavour of the narrative. Thus a regressive narrative would have an overall pessimistic tone whereas a progressive narrative would have an optimistic tone, while a stable narrative would have a more objective tone and would be more like a chronicle or a listing of events.

Gee (1991) described the value of exploring the poetic structure of popular narrative accounts. He argued that verses are an intrinsic part of everyday narrative accounting and that poetry is merely a more developed form of that accounting. In particular, he was concerned about the use of rhythm and metaphor in popular narratives. The study by Becker (1999) is an example of the successful use of this strategy to

explore personal narratives. In reading through the pain narrative of an elderly person, she noted that it had a certain poetic quality. She was then able to recast the narrative account as a series of poetic stanzas that each had a similar structure. In recasting the narrative, the interviewer's questions are omitted and the text is organized into verses by the researcher. This form of analysis requires attention to the overall rhythm that underlies the narrative and the metaphors used to describe particular experiences. For example, the narrator may repeat certain phrases within her account (such as 'and then I') which provide a certain rhythm.

Besides the structure of the narrative there is also the imagery used, the major themes and the values underlying the account. McAdams (1993) argues that the two central themes in life histories centre around power and love which emphasize the importance of agency and having relationships. The importance of these themes varies across individuals and situations. These themes also underlie the major beliefs and values in a person's narrative account. Thus a focus on agency and power places an emphasis on individual rights and autonomy while a focus on relationships values the group and interpersonal relationships.

The researcher can also consider the personal, interpersonal, group and societal contexts (Murray, 2000). The personal context is concerned with

how narrative draws on the experience of the individual. According to McAdams the early experiences of attachment and loss colour how we react to situations in our later life. The interpersonal and group context takes into consideration the audience and the co-construction of narrative; and the societal context considers the broader social narratives which structure our everyday accounts. While it is difficult to integrate all these contextual levels into a single analysis, attention to one or the other may be particularly important in understanding the structure of certain narrative accounts.

In this chapter, we will consider the structure of a personal narrative account and the value of different analytic strategies. We will begin by summarizing the case, proceed to how the narrative is structured, and then consider how the narrative is located within a particular social context. Although we will consider in detail only one case, it is useful in developing an argument to explore contrary cases. We will consider briefly a contrary case. This process enables the researcher to clarify particular strategies used by the participants in constructing their narratives.

An Example: A Breast Cancer Story

The example is taken from a study of how women handle the disruption of their lives as a consequence of having had breast cancer (Murray, 2002). We

were interested in how the women integrated the disease into their everyday lives – how they gave it meaning. We were also interested in how these stories were constructed in a particular social and interpersonal context. In this sense, we were interested in how the broader social context intersects with the personal narratives.

All the women interviewed had had surgery for breast cancer. At their last check-up, there was no sign of recurrence and they had agreed to be interviewed about the experience. The interviews took place in the women's homes or in the researcher's office. A young female research assistant who had no personal experience of breast cancer conducted them. For many of the women, the interview was an emotional experience. Several of them mentioned that they had had limited opportunity to discuss the operation with others. They felt that they had to present a strong face to their husbands and family members. The opportunity to talk freely about the event was largely welcomed. It is important that inexperienced researchers are briefed on the emotional intensity of some narrative interviews and that they have the opportunity to discuss the experience afterwards with their supervisor.

We can begin by preparing a summary of each of the narrative accounts. There were certain commonalities in all of the stories that

gave them the standard narrative structure:

Beginning: this was life before cancer. Different women emphasized particular aspects of their lives – family life, marriage, work, children, etc. The main thing was that cancer did not play a part in their lives. Some of the women tried to identify early experiences that might have contributed to the later development of the disease.

Middle: the major part of the story centred around the diagnosis of cancer, the surgery (radical or otherwise) and the reaction of the patient and that of their family, friends or colleagues.

End: this involved looking back on the disruption in their lives; how they began to redefine themselves as a survivor of the disease, how their life expectations and experiences changed.

For some researchers, summarizing all the interviews can be a tedious task. However, it is an important task, as it makes the researcher familiar with the different narratives. It is also important in developing an analytic frame that can encapsulate all the narrative accounts. Thus, we develop an initial analytic frame and then engage with the other narrative accounts, all the time

considering its adequacy and how it can be modified.

Having developed the analysis of the narratives, we can then proceed to writing a report or paper that is grounded in the interviews. It is important to have in mind what is the key argument or message that you want to convey from your reading of the narratives. It is then possible to select paradigmatic cases that best illustrate the central argument being developed by the researcher (Becker, 1997; Gray et al., 2002). In this chapter, I have chosen two cases that illustrate how people make sense of illness though connecting their current experiences with earlier life experiences. The selection of the narratives was guided by our understanding of Gergen and Gergen's (1984) temporal model and by McAdam's approach to the study of narrative which has been further developed by Crossley (1999). An initial reading of the narratives suggested that these models were a useful means of organizing much of the material.

The stable/regressive narratives were those with a pessimistic tone which portrayed life as being a litany of woes. In these narratives, childhood was described as being difficult with few improvements since becoming an adult. Despite many attempts to overcome various challenges, they seemed to be endless. Not only did these challenges recur but they also seemed to have little redeeming value.

Cancer was another of these bleak challenges. The case of Mrs. Brown, which is described in Box 6.2, illustrates this stable/regressive and pessimistic narrative. The dominant theme was that of attachment and loss. In her earlier life Mrs. Brown had experienced separation and was now very anxious about the consequences of the cancer on the relationships enjoyed by her children. As a single parent she had a very close relationship with her children. The thought of them experiencing similar childhood experiences as she had filled her with dread. She emphasized the lack of support she had received from others. A recurrent image was that of being alone: she had been alone as a child; she had not been able to establish a stable relationship with the father of her children or another partner; and she felt very alone when she was initially diagnosed with cancer.

A contrary narrative is one in which life is portrayed as a series of challenges that provide an opportunity for advancement. Even life threatening events such as the diagnosis of cancer could be characterized as such an opportunity. The case of Mrs Jones, which is summarized in Box 6.3, illustrates this more progressive and optimistic narrative. She had given her 'heart to the Lord' at an early stage, and ever since she had felt her life to be a series of life-enhancing opportunities. Cancer was one of these

opportunities. In Mrs. Jones' case attachment was secure, in particular through her attachment to religion. As she said, she had given 'her heart to the Lord'. In view of the intensity of this attachment the threat of cancer was minimized. She adopted a rather fatalistic stance and in some ways her story had tragic features. However, the crises she encountered were perceived as God's will and He would take care of things. Her recovery from cancer was evidence of His power. A recurrent image was that of security and comfort. The crises she experienced seem to strengthen rather than weaken her attachment to religion.

Besides these two contrasting narratives, many other women interviewed provided what could be described as more even or stable narrative accounts. They tended not to highlight particular events in their lives but to describe them in almost mundane terms. The diagnosis of cancer was another such routine event. This threefold characterization of the accounts of cancer (stable/regressive, progressive opportunity and stable/routine) provides a useful means of exploring the connections that the narrators place on their lives and the different narrative identities constructed in their accounts.

Box 6.2 Stable/regressive / Pessimistic narrative

Summary: Mrs Brown was a 50-year-old single mother. She described her upbringing as difficult. Her mother died when she was 2, and she and her siblings were sent to different orphanages. There they were very badly treated by the guardians. On leaving the orphanage, she trained to be a nurse. She found it difficult to establish a secure relationship but wanted to have children. She had three children by different partners but never married. Two of the children had grown up and left home. The third was aged 12 years. She had not held a full-time job for about ten years. About ten years ago, she had been diagnosed with breast cancer and had undergone a lumpectomy. Mrs Brown's life was difficult and the diagnosis of cancer was devastating. This summary can be extended into a three-part narrative to help clarify particular features.

Beginning: Throughout her account Mrs Brown emphasized her problems. She described her childhood in the orphanage as a very painful experience. Not only was she separated from her siblings but she also felt that the teachers were very harsh towards her. After she left the orphanage, she found it difficult to establish relationships. In general, her life was difficult.

Middle: The diagnosis of cancer was yet another ordeal. At the time, she was not working, she had three children and she was finding it difficult to make ends meet. When the surgeon told her she had cancer she was very upset:

Mrs B: It really flipped me right out.

Int.: Yeah.

Mrs B: It really flipped me out, but it was so quick.

Int.: Hmm, hmm.

Mrs B: Like, I never had time to stop and think.

Int.: Right.

Mrs B: Like, they told me, and then I cried for three weeks, and then next week I was in hospital and had it all done.

She had a lumpectomy, and on discharge from hospital she found it very difficult to cope:

Int.: Was it a mastectomy or a lumpectomy? Mrs B: No, it was just a lumpectomy.

Int.: OK.

Mrs B: Right, and so I went through all that, and then I went through a year of chemo and radiation and went through hell, but like by myself.

Int.: Hmm, hmm.

Mrs B: You know, no husband and three little kids. They were young then, right.

Int.: Oh, it must have been hard.

Mrs B: And it was terrible, it was absolutely terrible. I had no moral support. I had no one here to help.

Mrs Brown emphasized that without any social support from family or friends and the fact that she had lost any religious belief because of her difficult childhood experiences, the experience of cancer was frightening.

End: Looking back, although she had survived, the whole experience was difficult. Sometimes she would blame God for her misfortune:

Int.: Did you ever think 'why me?'

Mrs B: Oh many times.

Int.: Yeah?

Mrs B: Many times, like holy, never stops, never stops. I be scrubbing the floor, I be scrubbing out a tub, I be bathing one of the kids, I be like 'why, why?' you know. There's no one here to take these kids. Int.: Hmm, hmm.

Mrs B: Why are You taking me? I thought I was going to die.

Int.: Yeah.

Mrs B: Naturally.

Int.: Hmm, hmm.

Mrs B: You know, somebody tells you 'you got cancer'. First thing, I'm dead.

The ongoing fear of death pervaded her everyday life: 'You have it, it never leaves you. I don't care what I'm doing. I could be baking bread and I'm always thinking. It was always there with me, maybe it's because I'm alone.' She was very anxious about the implications for her children if there was a recurrence of cancer:

Mrs B: If it happens tomorrow, and he's only 12, I will flip. I will go really, really crazy.

Int.: Hmm, hmm.

Mrs B: Yeah, because what's going to happen to him?

Int.: Yeah.

Mrs B: Welfare would come and take him. [I] always worry about that kind of stuff. I worry about all that kind of stuff.

She felt despondent about her future life:

Mrs B: Just give me more life and just keep it going and don't take it on me – that's the main thing.

Int.: Yeah.

Mrs B: You know and like I don't aspire to any greatness or anything.

Int.: Hmm, hmm.

Mrs B: I really don't. I don't aspire to going back to work and to make another life and to go travelling again. I never think of it. It seems like a dream.

In terms of narrative structure, Mrs Brown's story is both stable and regressive. Her whole life had been difficult and the diagnosis of cancer only served to highlight these problems. The lack of social support and the lack of religious faith left her feeling isolated. She felt she had substantial family responsibilities and cancer threatened her ability to live up to these responsibilities. Although she had managed so far, the potential recurrence of cancer remained a threat.

Connecting the Stories with the Context

This example of narrative accounts of the experience of cancer illustrates the way people can use narratives to forge 'links between the exceptional and the ordinary' (Bruner, 1990: 47). When given the opportunity in the interview, the women were eager to provide detailed narrative accounts. Indeed, once she had introduced the topic, the interviewer's role was minimal. Often the women were enthused at the opportunity of providing a detailed narrative account of their experience. Sometimes they mentioned that they felt that the giving of the account was therapeutic.

This eagerness to talk after surviving a personal threat is an established phenomenon. In religious terms, the phenomenon is known as 'giving witness', a term that in Greek is cognate with such terms as 'martyr' and 'testimony' (Scott, 1997). The public display of giving witness has spread from its original religious form to a more secular form in the modern world through the phenomenon of 'coming out', which has extensive currency not only in terms of sexual identity but also in terms of survivors of abuse and torture. This form of public narration is a means of developing a community of support and also of challenging certain repressive societal narratives.

Box 6.3 Progressive /Optimistic narrative

Summary: Mrs Jones was a 45-year-old married woman. She had six children. Although she had previously worked as a teacher, since the surgery for breast cancer she had devoted herself full-time to religious work. When she was young, she had not been particularly religious, although she had attended a Catholic church and school. When she was 16 years old, she met her future husband, who was a very devout evangelical Christian. Mrs Jones converted to his religion, and since then her devout religious belief has pervaded her whole life, including her experience of cancer. For her, having breast cancer was an opportunity to strengthen her faith and as such could be welcomed.

Beginning: Early in the interview, Mrs Jones provided a detailed account of her religious conversion: 'I started going to the Salvation Army church first and then started going to the Pentecostal church. So after we got married I kept going to the Pentecostal church and I gave my heart to the Lord and I have been going there since.'

Middle: She was diagnosed with breast cancer and underwent lumpectomy. Initially, the signs were good, but at follow-up there were signs of recurrence. Mrs Jones described the importance of her faith. The surgery was successful and at the time of the interview there were no signs of recurrence. Mrs Jones felt very optimistic: 'I feel that I'm healed. I feel that the Lord healed me.'

End: Looking back, Mrs Jones emphasized the positive experience of having cancer: 'I think that everything in life has been an experience to make me grow and I think it has brought me closer to the Lord.'

This narrative account was progressive. Although cancer was a major challenge, Mrs Jones had transformed this into an opportunity for heightened religious experience. Her narrative account became almost a testimony in itself. Throughout she gave praise to the Lord and all his glory. Her narrative was one of liberation. The disease strengthened her faith. Her recovery was confirmation of the power of religion.

In terms of structure, the women's stories had the classic beginning, middle and end. The beginning set the scene, the middle detailed the experience of breast cancer, and the end concerned the impact of the disease on their lives. In the example, the stable/regressive and pessimistic narrative connected the woman's account of cancer with her previous experiences, the interpersonal context and her broader social beliefs in creating a particular narrative identity. For Mrs Brown, life had been difficult. At a time when she felt she had little support, she was diagnosed as having cancer. This was just not fair. She felt that she did not ask for much out of life. Her narrative ended with almost an appeal to let her be healthy at least until her youngest child had grown.

At the personal level of analysis, the narrative reflects the different experiences of the women. Mrs Brown came from a broken family and felt very insecure in her relationships. The main challenge concern for Mrs Brown was her responsibilities to her children. The onset of cancer was a major threat to

this and thus was a threat to her life chances. In developing her narrative account, Mrs Brown works backwards from the present, describing earlier experiences of difficulties and lack of support. There is a coherence in the narrative identity that she presents.

At the interpersonal level, the narrative analyst is interested in how the participant conveys her story to the interviewer. In her story, what issues does she emphasize? Her whole life has been one of trials and she does not expect much in the future. 'I don't aspire to greatness,' she says. In comparison to her, the young interviewer was fortunate. She seemed to be healthy and in good employment. The diagnosis of breast cancer was yet another tribulation for Mrs Brown. During the interview, she spent considerable time detailing her childhood experiences of abuse and connecting this to her current circumstances. Her narrative account was developed in opposition to what was perceived as a less painful life history.

At the societal level, these narrative accounts reveal mesh with

the broader moral universes or the underlying values of the women (McAdams, 1999). The dominant theme in the lives of the women described earlier was that of relationships emphasizing the importance of communal values. This finding accords with Gilligan's (1993) idea that women centre their discussions of moral issues around communal care and responsibilities. Thus in the case of Mrs. Brown it was not right that her children's relationships could be jeopardized as hers had been. In the case of Mrs. Jones her relationship with God was secure and thus she was able to transform her illness into an opportunity for growth. Underlying this transformation was a belief in the agency provided by religious faith. From a moral perspective (Noblitt and Dempsey, 1996), narratives can be seen as tales of right and wrong, of attempts to do the virtuous thing during times of challenge. For Mrs Brown, the moral universe was one of emptiness and despair. God had in many ways let her down before, and this was one more piece of evidence to illustrate that she had been rejected by the world. Without this belief in the sacred, she found it difficult to see any transcending qualities in the experience. Conversely, Mrs Jones had strong religious convictions; an all-pervading spiritual glow pervaded her universe. For her, the experience of cancer was transformed by defining it

as an opportunity presented by God to reassess her life.

Further Analyses

This example provides an illustration of the process of narrative analysis. It is not the only way of conducting such an analysis. Unlike other forms of qualitative analysis that break the interviews down into themes, the aim of the narrative analysis is to take the full narrative account, to examine how it is structured and to connect it to the broader context. The important challenge is that the researcher is explicit in the initial theoretical formulation and then engages with the narrative account.

The narrative researcher can bring different theoretical frameworks to help make sense of the story told. Hollway and Jefferson (2000) compare the process of theoretical engagement with tossing a stone into a pond. An appropriate theory will spread its ripples out through the narrative account, revealing particular features that had been neglected by another theory. They used a psychodynamic framework that considers hidden anxieties as providing an underlying structure in narratives. Applying this framework to the breast cancer narrative previously discussed, we can begin to connect the woman's anxiety about her early experience of abandonment to her fear about the impact of the cancer on her children.

In narrative accounts developed in focus groups, it is important to note

how collective stories are developed. The identification of collective terms such as 'we' and 'us' can assist in identifying these more social narratives. They can also be seen in the way some narratives are developed in contrast to the stories of the collective 'other' that are described using terms such as 'they' and 'them'. These terms are also apparent in individual narratives and illustrate to what extent the individual identifies with certain social stories or attempts to develop more oppositional narratives.

The researcher can also involve the participants in the process of narrative analysis. For example, one could ask them to review the narrative transcripts or their personal journals and to highlight certain features of interest, in a way for them to begin to develop a coding scheme. From this review, they, either as individuals or as part of a group, can begin the process of analysis. The researcher could also use the study of the narrative accounts as the beginning of a process of reflection for the participants. An extension to the

cancer study described would be to invite the women to participate in a group setting to reflect upon their common experiences. Such a process could be emotionally charged for both the researcher and participants, but it also holds the possibility of converting the narrative research into a form of action research (see Chapter 10 of this volume; Lykes, 1997). In this form of research, the participants can begin to reflect upon the power of dominant societal narratives in shaping their experiences and, as a group, to consider alternative, more enhancing narratives.

In conclusion, the opportunities provided by narrative research are extensive and still being developed. In conducting a study, researchers should ask what are they trying to understand, what are the participants trying to say and why are they trying to say that. The aim is to reveal the underlying structure of narrative accounts that shape not only the way we account for our actions and those of others but also our very identity.

CHAPTER 8

NARRATIVE PSYCHOLOGY AND NARRATIVE ANALYSIS

"It was long ago, and long ago it was; and if I'd been there, I wouldn't be here now; and if I were here, and then was now, I'd be an old storyteller, whose story might have been improved by time, could he remember it. Three good points about stories: if told, they like to be heard; if heard, they like to be taken in; and if taken in, they like to be told. Three enemies of stories: endless talk, the clash of a mill, the ring of an anvil -"
(Carson, 1996)

The above quotation is the opening paragraph from a recent prose work by the Irish writer Ciaran Carson. It provides an introduction to a wondrous book of tales in which Carson intertwines stories told to him by his father with ancient Greek myths and with stories about Dutch painters. It also provides a fitting introduction to this chapter in that it summarises both the pervasiveness of storytelling in everyday social interaction, the role of plot and memory in narrative, and how in the modern era storytellers have become very self-conscious of the telling. It is perhaps because of the very pervasiveness of stories that it is

only recently that psychologists have become interested in studying narrative.

Brian Richardson (2000) begins his introduction to a recent special issue of the journal *Style* devoted to the study of narrative with the sentence "Now, narrative is everywhere." Whereas twenty years

ago the study of narrative was confined to literary scholars it has now spread across all the disciplines from the humanities through the various social sciences and even touching the physical sciences. In this chapter we review the nature of this so-called 'narrative turn' within psychology, detail how to conduct narrative interviews, and consider some forms of narrative analysis of personal accounts.

Narrative psychology is concerned with the structure, content, and function of the stories that we tell each other and ourselves in social interaction. It accepts that we live in a storied world and that we interpret the actions of others and ourselves through the stories we exchange. Through narrative we not only shape the world and ourselves but they are shaped for us through narrative. In this chapter we review the nature of the narrative turn within psychology, detail how to conduct narrative

interviews, and consider some forms of narrative analysis.

Narrative as theory

Unlike other forms of qualitative research, narrative psychology is not only concerned with methods but also with broader ontological issues. Narrative underlines our very being and our way of acting in the world. We begin by considering some of these broader theoretical issues before we consider any of the methodological issues.

Narrative turn in psychology

The study of narrative accounts has a lengthy history in modern psychology. Indeed, we can trace it back to Wilhelm Wundt (18xx-19yy) who is often considered the father of experimental psychology but who also developed a parallel approach termed *Volkerpsychologie* that considered the importance of such phenomena as myths and legends in human life. In the twentieth century, despite the domineering approaches of behaviourism and instrumentalism, a steady stream of psychologists turned to the study of more open personal accounts to deepen their understanding of the human condition. For example, during the 1930s, Gordon Allport led a project concerned with examining the life histories of refugees from Nazi Germany (Allport, Bruner & Jandorf, 1936). Subsequently he prepared a report on the use of personal

documents in psychological research (Allport, 1942). In the preface to that report Allport wrote:

“A decade of depression, war and misery has had one benign effect. It has brought out upon the central stage the struggles of the common man, the picture of his daily life, all his homely values. It has brought the documentary film into popularity, the opinion poll ... autobiographies that give unaccented accounts of ordinary experience.”

As we enter the new millennium once more the voice of the common man and woman has come to the fore in both popular culture and in the human sciences. Today, one of the most popular of literary genres is the autobiography, not just of the political leader but of the everyman. On television one of the most popular formats is not the documentary which gives precedence to the expert voice but the talk show which provides a forum for the ordinary person to tell their stories.

This enthusiasm to tell and listen to popular life stories could be described as a marker for a society that is losing faith in its more established narratives of religion and science. Now we turn to each other for advice and guidance (cf. Chandler, 1990).

One of Gordon Allport's original research assistants was Jerome Bruner who has become a leading contemporary promoter of the

narrative turn within psychology. Bruner (1986) has argued that there are two ways of knowing - the paradigmatic and the narrative - each distinct and "irreducible to one another" (p. 11). The former is based upon the process of classifying and categorising which is preferred by the natural sciences. It tries to "fulfil the ideal of a formal, mathematical system of description and explanation" (p. 12). The alternative narrative knowing is a popular means of making sense of the world by connecting events over time through stories. This narrative mode is the dominant process of thinking within what Bruner termed 'folk psychology', mirroring Wundt's earlier term.

One of the central features of this narrative knowing is that it 'specialises in the forging of links between the exceptional and the ordinary' (Bruner, 1990; p. 47). It provides a means of integrating the strange and unknown into the realm of everyday life. 'The function of the story is to find an intentional state that mitigates or at least makes comprehensible a deviation from a canonical cultural pattern' (Bruner, 1990; p.49-50). This argument may seem commonplace but it challenged the dominant atomistic trend within cognitive psychology that attempted to break human thoughts down into the smallest parts. Instead, according to Bruner (1990) 'people do not deal with the world event by event or with text sentence by sentence. They frame

events and sentences in larger structures' (p. 64). However, we do not tell stories about everything but especially about those events that deviate from the standard.

Other psychologists (e.g. Polkinghorne,1985; Sarbin,1986; Gergen & Gergen,1986; Murray, 1997a,b) have argued that narrative is a human means of making sense of the world. In providing accounts of our everyday lives we speak in narrative form. Further, we draw upon the narrative accounts of others. As Sarbin (1986) states:

In giving accounts of ourselves or of others, we are guided by narrative plots. Whether for formal biographies or autobiographies, for psychotherapy, for self-disclosure, or for entertainment, we do much more than catalogue a series of events. Rather, we render the events into a story. (p.)

The French philosopher Paul Ricoeur (1986) in a series of articles and books has developed a sophisticated thesis for the centrality of narrative in human thought and identity. One of the central planks of Ricoeur's thesis is that we live in a sea of time. Narrative, as it were, provides a map of that sea - it brings order to disorder. A central feature of this narrative process is emplotment whereby we drive "a configuration from a succession" (1986, p. 427). Admittedly, before we provide this

order or shape, Ricoeur argues, there exists a pre-narrative structure to our reality that 'constitutes a demand for narrative' (1989, p. 74) but also limits the shape we can give to our narrative account. However, the narrative interpretation of our reality is central - without it we continue to be awash in a sea of time.

The stories that we tell about lives are social constructions. In constructing a narrative account we make use of everyday language. As Ricoeur (1997) has stressed, the social nature of language conditions the character of our narrative accounts: "It is together that we remember; and it is within the social medium of language that we articulate our most individual memories in the mode of narrative" (p. xliii). Further, we share stories about our lives with each other. We live within a web of family, community and other stories. To continue the nautical analogy, we swim in a sea of stories that seeps into our consciousness and our very identity.

What is narrative?

So, what precisely does the term narrative mean? The very pervasiveness of the term can lead some researchers to suggest that narrative can be any form of text or discourse. However, there are certain distinguishing features. The most distinctive feature is that it provides a coherent causal account of an event that has occurred or will occur. This

definition includes both the casual and temporal dimensions of narrative. Narrative provides a certain shape, structure or plot to a sequence of events. In any culture there are many such plots that we can draw upon to shape our interpretation of events. Some cultures may have a greater range of plot lines than others and it is even possible that in certain societies the range is minimal or non-existence. Since narratives provide shape to our past and projections about our future it would be expected that such cultures would have limited history or plans for the future but instead their members would live largely in the present.

Narratives do not simply exist, they are created in our everyday social interaction. We tell stories to someone. Indeed, this social nature of narrative is one of its distinguishing features when compared to such other forms of imagination as dreams. While some researchers suggest that we dream in narrative this is not clear. Indeed, according to the early French social psychologist Maurice Halbwachs (1992), one of the particular features of dreams is their lack of structure, their very fluidity. Dreams could be considered analogous to Ricoeur's pre-narrative experience. It is this quality which provides their mystery and sometimes-associated anxiety. Dreams exist in a lonely world. They contain disconnected sequences of events that can be strange or 'dream-like'. They

melt away when we awake. When we attempt to recall them it is difficult whereas when we attempt to recall stories it is more straightforward. Stories exist in a social world. In providing accounts of experience we actively organise them in narrative form so that they can be grasped by the other. In addition, they are partly organised for us by the other person and by the culture in which we live. They are co-constructions (see Mishler, 1997).

The plot is what gives the narrative account its structure. As Polkinghorne (1985) states:

Plots mark off a segment of time in which events are linked together as contributors to a particular outcome. The segment of time can range from the boundless (the story of God's creation of the universe), to centuries (the story of the settlement of the United States), to life stories (biographies), to daily or hourly episodes (the story of going shopping). In each case the story established the beginning and end of the storied segment, thereby creating the temporal boundaries for the narrative Gestalt. (p. xxx)

Admittedly, there are events that seem to challenge standard plot lines. These are the events in our lives that do not fit easily into a coherent form. It is this difficulty in creating a narrative about certain personal or

societal events that can leave a person or a community adrift, uncertain and anxious. Narrative therapists such as White and Epston (1990) have suggested that the reason people seek help are because their narrative repertoire does not sufficiently encompass their everyday experiences.

The aim of the psychotherapy is to help them to expand their repertoire, to construct new and more satisfactory stories. Rather, than trying to adjust disconnected cognitive distortions, which is the preferred method of much therapy, narrative therapists prefer to explore the larger plot lines in a person's life story. These plot lines may reflect the dominant societal plot lines that do not accord with personal experience. The aim of the narrative therapist is, together with the client, to challenge these dominant plot lines and to generate alternative stories.

The adequacy of personal and societal plot lines to encapsulate particular social tragedies has been considered by historians such as Lawrence Langer. In his analysis of holocaust testimonies, Langer (1991) found that the accounts of survivors were often disjointed and unfinished - it was not possible to fit the horrors into a standard narrative form. This lack of narrative coherence threatened the survivors' essential inner self. The only way some of them could proceed was by developing a new self built on new stories. However, the foundation for this new self was tenuous and led to ongoing personal and social

difficulties. Langer also argued that it is not just at the personal level but at the societal level that this challenge to narrative exists. Developing a coherent social narrative for these horrors would only contribute to the banalizing of the barbarity of the holocaust. An agreed social narrative provides a society with an interpretive structure that enable it to grasp, to understand and possibly to excuse. For Langer, and some other Holocaust historians, such a process diminishes the magnitude of the evil and enables Western society to, as it were, move on. Leaving it in its pre-narrative shape ensures that it remains forever in our consciousness as a testimony and as a memorial (Langer, 1998).

The telling of narratives is closely intertwined with the shaping and maintenance of personal identity. We tell stories to ourselves and to others about our lives. In this way our lives are represented in narrative form. McAdams (1985) has been to the fore in promoting a narrative approach to the study of human personality. 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 that 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. 19)

Admittedly, this characterisation can be considered rather individualistic in that it ignores the social context within which the stories are created. It is as if the individual could create any story s/he desires. An alternative approach is to argue that the construction of narrative identity is much more dialogical and occurs within a social context. Admittedly, the social context may be both real and imaginary. As Hermans, Kempen & van Loon (1992) suggests: "Imaginal dialogues play a central role in our daily lives: They exist alongside actual dialogues with real others and, interwoven with actual interactions, they constitute an essential part of our narrative construction of the world" (p. 28)

In discussing the role of narrative of constructing our identities, Ricoeur distinguishes between configuration and refiguration. The former is the primary activity by which the narrative brings structure to the world through various forms of emplotment. The latter is the means by which the author defines himself through narrative. There is a constant interchange. This interchange occurs in a social world. We draw about cultural plot lines to create our stories and define ourselves. Further, our narrative identities are not fixed but fluid. This very fluidity is the focus of much contemporary debate about identity (e.g. Gergen, 1991). It is an

issue that influences not only the way we collect but also analyse personal accounts.

The structure of narrative accounts is not fixed but depends upon a variety of factors including the narrator, the audience and the broader social and cultural context (see Murray, 1997a). The character of the relationship between the narrator and the audience is of central importance. The narrative is created in this exchange. As Freud (1937) stated in describing the analyst-analysand exchange:

'The analyst finishes a piece of construction and communicates it to the subject of analysis so that it may work on him; he then constructs a further piece out of the fresh material pouring in on him, deals with it in the same way and proceeds in this alternating fashion until the end'.

The story is co-constructed by the two or more parties to the exchange. Admittedly, one of the parties may have more influence than the others such that s/he can shape the narrative. This dominant plot-line may or may not accord with the experience of the other. As we will see, this question regarding the relative contribution of the different participants in shaping a narrative is an ongoing challenge facing the narrative researcher in collecting and analysing narrative accounts.

We can extend this concern with social context to consider broader issues of social power (e.g. Murray, 2000). Foucault (1980) has emphasised power pervades social relationships. Societal narratives are not value neutral but represent various power interests. The adoption of dominant narratives becomes a means of self-discipline. People are constantly engaged in a process of renegotiating these dominant narratives. As Morawski (1997) argues:

Narratives serve as mediations between individual actions and material and social-structural conditions; they reflect the dynamics of ongoing negotiations, interpretations, and construals just as they indicate the constraints operating in these dynamics. (p. 675)

An awareness of the role of these dominant narratives in our everyday lives opens up transformative possibilities (see White & Epston, 1980).

Collecting personal stories

Within the research context the primary means of obtaining narrative accounts is through interviews. Indeed, in the interview situation the interviewee is often keen to give narrative accounts but is discouraged from doing so by the researcher. As Mishler (1986) has argued:

"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."

Conversely, narrative researchers place the collection of narrative accounts at the centre stage of their interviews. They ask for narrative accounts and encourage them wherever possible.

One of the particular strengths of the narrative interview is that it gives the research participant much more central control in shaping the agenda. In the standard interview the researcher brings to the interview a series of questions or theories s/he would like to explore. In the narrative interview the researcher asks the participant to identify the major themes. For example, you could start a narrative interview with the open request: "Tell me about yourself". The participant may be somewhat bemused by such an open agenda and reply "Where do you want me to begin?" to which the researcher can reply "It's up to you."

The challenge for the researcher is to encourage the participant to tell his or her story. This brings into play the standard advice on being empathetic and supportive to the interviewee. For some people the opportunity of an open agenda is

seized and they will proceed to tell extensive stories about their lives with very little encouragement from the interviewer. Conversely, other participants will be reluctant to speak - indeed the very openness of the narrative interview may invite suspicion and anxiety leading to brief answers and long pauses. It is unlikely that one meeting with such a person would be sufficient. Rather, it would be necessary to meet with them on several occasions to allay their suspicions. An alternative approach would be to offer him or her the opportunity of participating in a group discussion where they could gain confidence through participating in the exchange of stories with colleagues from their own community.

The successful narrative interviewer needs to get to know the research participant. It is not an employment interview where the interviewee feels constrained to edit out all the embarrassing incidents. The interviewee needs to feel that her story, warts and all, is deeply valued. Oftentimes this can be difficult. The interviewee may remain suspicious at the openness of the narrative interview or feel that their stories are not worthy of research investigation. This resistance can tax the patience of the naive interviewer who may feel that despite her many attempts the interviewee continues to be excessively restrained.

Admittedly, times are changing. The narrative turn in the social

sciences reflects broader changes in society. As previously mentioned, the public display of personal stories has increased the legitimacy of personal storytelling. Elderly people are especially receptive to the extended narrative interview. Indeed, it would seem that their very position in the life course provides them with a perspective to look over their lives. Freeman (1997) suggests that later life is the narrative phase par excellence. The reason for this is that in later life one has gained a certain distance from the life one has lived. It is then possible to size up events and draw connections over time. Further, their life history will itself have reduced some anxieties or qualms about the whole interview procedure. Since the researcher will often be young the senior sometimes feel more comfortable about taking control over the interview.

The aim of the narrative interview is to obtain a detailed account of a particular broad area of interest. It is most frequently used in biographical and life history research. In this case the researcher outlines at the outset the purpose of the interview and then guides them participant through the account from beginning to end. For example, the interviewer could start: "I would like you to tell me the story of your life beginning as far back as you wish and recounting as much detail in your life up until the present." During the account the interviewer can intersperse the

account with such comments as "What happened next?" or "Can you recall anything else?" The main emphasis is on how the participant connects events together.

This life course interview can be extended to different developmental sequences. For example, it can explore the process of "becoming a psychologist" or "leaving home". The main concern is that there is substantial opportunity for the narrator to cast a narrative net over a chronological sequence of events. In his narrative account the author can deviate from the sequence, select certain events and ignore others. The following is an extract from the beginning of a narrative life-course interview.

First narrative interview

Interviewer: Can you just tell me a little about yourself, what you used to do, that sort of thing?

Senior: I'm writing a book on that, not all of it. Well, I grew up ... I was born in the 20s, of course ... I grew up and lived my life in Port-town until I was 18. Then I went to work for the British Customs in Hill-town with the idea of being transferred to Eagle airport in a couple of months, like basic training. I was there and I spent a year ...

This interview extended for almost two hours. The interviewer said little and the senior proceeded to review his life in extensive detail. Much of it concerned his working life confirming the centrality of work in his life. Admittedly, this senior was particularly loquacious and eager to provide substantial details of his life history. The second narrative interview that was conducted in the same project illustrated how some people are not as forthcoming.

Second narrative interview

Interviewer: Can you tell me a little bit about yourself, what you used to do, where you grew up, that sort of thing?

Senior: I can't even remember, nothing exciting.

Interviewer: Where did you grow up?

Senior: I grew up in Jamestown. I looked after a bunch of children, of course, my brothers and sisters.

The second interview continued in this question and answer format. The problem in adopting this approach is that the interviewer takes the lead role and begins to shape the narrative. This is an important reason for ensuring that in transcribing the interview that both the interviewer's and the interviewee's remarks are transcribed.

Flick (1997) distinguishes the life-course narrative interview from the episodic interview that is much

more focussed. The interviewer has a more structured series of issues that s/he would like the interviewee to discuss. However, unlike the standard interview that is structured on a more abstract level the episodic interview will seek more detailed narrative accounts about the interviewee's experiences with these topics. The role of the interviewer is to emphasise to the interviewees that they would like them to expand upon personal experiences. In many ways the episode interview sets out to deliberately challenge the attitude-scale questionnaire format which has pervaded contemporary society. While it can lead people through a series of issues or experiences the purpose is not to get them to rate these on a five point scale but rather to give extended narrative accounts about them.

In collecting personal accounts we need to be aware that the very interview process itself may encourage a certain structure for those accounts. In particular, it may encourage a certain narrative coherence. As Hollway (1989) has argued:

Participants usually strive for coherence in the narratives they produce (for research as for other purposes). This is one effect on subjectivity of the dominant Western assumption of the unitary rational subject. (p. 43)

Squire (2000) in her study of personal accounts of people with HIV questions

the constraints placed upon an individual in a narrative life-course interview. She felt that there is a tendency in the contemporary focus on obtaining extended autobiographical accounts to create a false 'seamlessness, homogeneity' (p. 199). In the same way, Eakin (1999) argued that autobiographies emphasise the central role of the author to the neglect of others. One way to challenge this tendency, suggested by Squire, is to encourage the telling of a series of autobiographical stories rather than a single autobiography. Such an approach combines the episodic with the traditional narrative life-course interview.

An important issue in the collection of narrative accounts is the issue of reflexivity. This issue concerns the researchers' own awareness of their role in shaping accounts. The researcher brings to the interview a range of presuppositions. These may encourage certain narratives and inhibit others. Awareness of this potential provides the researcher with the opportunity to question restrictive narratives and to promote more emancipatory ones. This of course leads away from the traditional value neutrality within positivist psychology and provides an opportunity for narrative researchers to adopt a more activist stance. Lykes (1997) has discussed how she engaged Mayan women and children in Guatemala who had suffered sustained political oppression in

developing a new story of their lives. Through ongoing group discussion the survivors began to break from their previous silence and to develop a new shared narrative of strength and resistance. This approach provides an opportunity to connect narrative research with the broader participant action research. It also emphasises that broad societal narratives can shape how we react to various experiences.

Narrative analysis

There are a variety of narrative analytic strategies. In other chapters of this book discourse analytic and other strategies are discussed. These can also be applied to the analysis of personal accounts. However, they ignore the narrative structure of the accounts. In this chapter we will confine ourselves to certain analytic strategies which focus on the narrative structure of personal accounts. The most important distinction is the deliberate concern with narrative structure, not with the particular themes within the narrative. Admittedly, in conducting a comprehensive analysis of personal accounts the researcher will look for particular themes. However, in interpreting these it is important to locate them within the particular narrative framework. For this reason it is essential that the researcher read the whole interview and familiarise themselves with the various issues raised.

The standard linguistic approach to the study of narrative was that developed by Labov (1972). This was very much a structural approach that broke the narrative account down into narrative clauses which could be categorised into six components: *Abstract* that provides a summary of the narrative, *Orientation* that sets the general scene, *Complicating action*, *Evaluation*, *Resolution* and *Coda*. The central component in the narrative is the complicating action and all the other components are only introduced in the more sophisticated accounts. In conducting this form of analysis the researcher reduces the transcript down to what is termed the 'core narrative' which excludes any material which is considered extraneous to the story-line. Admittedly, there may be a number of such 'core-narratives' within any extended interview. The key criterion for including material in the core is that it is a clause with some connection to the main story. Then the clauses are arranged into the six components identified by Labov. This approach enables the researcher to grasp not only the action core of the narrative account but also the interpretive orientation the participant adopts and the issues that the participant chooses to emphasise and to ignore.

Extensions of this approach are those narrative analytic techniques that borrow from literary criticism. The genre approach attempts to identify the broad type of the

narrative. Frye (1957) is the person best associated with this approach. From an extensive review of Western literature he argued that there were four archetypal forms: *comedy*, *romance*, *tragedy* and *satire*. More contemporary critics have extended this classification scheme. For example, Plummer (1995) has described the basic plots of the modernist tale as being a) taking a journey, b) engaging in a contest, c) enduring suffering, d) pursuing consummation, and e) establishing a home. He suggests that the common elements in these stories are a) suffering which gives tension to the stories, b) a crisis or turning point or epiphany, and c) a transformation. Gergen & Gergen (1986) proposed three broad narrative structures, viz., *progressive* where progress toward a goal is enhanced, *regressive* where progress is impeded and *stability* where no change occurs. This is not an exhaustive list but it provides an illustration of structural approaches to the study of narrative.

Gee (1991) has suggested that another textual approach is to consider the poetic structure of narrative accounts. Admittedly, many contemporary poets are adverse to using a narrative plot in verse but Gee has suggested that verse is often implicit in narrative accounts. Using this analytic framework the researcher must be aware of some of the basic poetic strategies used that may implicitly organise the narrative

account. In particular, the researcher needs to be aware of the rhythm of the narrative that confers stress on certain experiences and also makes connections with more established narratives. For example, does the narrator use a repetitive refrain to emphasise certain experiences or to connect with broader societal narratives?

A problem with linguistic approach is the tendency to focus on the structure of the narrative to the neglect of the social context within which it is constructed. Mishler (1997) has persistently argued for the necessity of understanding the interpersonal context within which the narrative account is constructed. As an example he contrasted two doctor-patient interviews. The first he terms "a facilitated story" which is punctuated with periods of silence. Also, when the patient speaks the doctor does not interrupt. Conversely, in the second interview, that Mishler terms "an interrupted story", the doctor deliberately directs the patient to focus on detailing her symptomatology. This process of encouragement through silence and direction through detailed questioning is also at work in the research interview. Thus it is important to consider not just what the participant said in the interview but also what the researcher said. For this reason in transcribing the accounts it is important to give as much detail as possible of the conversation both in

terms of words, paralinguistics and silences. In analysing the interviews it is also important to return to the interview tapes to clarify issues of emphasis.

The structure of the narrative account is also bounded by the broader social context. As Flick (1997) has emphasized:

In their concrete shaping, they [narratives] draw upon basic cultural narratives and life histories offered by the culture. The goal of analysing narrative data is more to disclose these constructive processes and less to reconstruct factual processes. (p. 206)

Thus in interpreting the narrative account we need to connect it with the broader cultural context. For example, although Squire used a genre approach in her analysis of HIV narratives she deliberately connected it to the broader social context. From reviewing the narrative accounts she suggested that the 'coming out' structure was the most popular genre. In their accounts the HIV patients struggled with the issue as to whether and who they should 'tell'. This analysis emphasised the ongoing tension in the HIV narrative accounts between accepting and rejecting the HIV identity. In her analysis Squire positions this struggle over telling within the broad social context of 'late modernity' and the ongoing debate about the singular self. Thus Squire is challenging the "longitudinal

consistency in the life story" that McAdams (1985, p. 18) argued formed the basis of the stability of narrative identity.

Connecting with Participant Action Research provides an opportunity for narrative researchers to adopt a more socially dynamic form of analysis. In her work Lykes (1997) conducted workshop sessions with terror survivors in Guatemala. She writes:

In this co-created group space, creativity is a resource for developing the possibility of modifying one's relations, reestablishing previously destroyed social ties, symbolizing one's experiences of the terror that one has lived, recuperating or reconstructing one's story, and searching for one's truth. (p. 730)

As a group the survivors became aware of the distortions in their

personal narratives and began to collectively develop a new more combative narrative. The new stories transformed them from victims into survivors (cf. Greenspan, 1998).

Challenging narrative coherence

In this chapter we began by emphasising that a pervasive feature of narratives is their quest for coherence. However, in the late modern era we are somewhat more sceptical of the capacity for coherence. In the same way, research reports evade the finitude of coherence and emphasise the multitude of narrative accounts. In practice, this plurality provides an opportunity for challenging the dominant plot lines. While narrative research provides an exciting opportunity to explore the social construction of identity and of reality it also offers a framework for promoting personal and social change.

CHAPTER 9

NARRATIVES ABOUT DISEASE AND THE BODY

Introduction

Latin America is famous for its storytellers. Indeed, such authors as Jorge Luis Borges (Argentina), Pablo Neruda (Chile), Octavio Paz (Mexico), Gabriel Garcia Marquez (Columbia), Mario Vargas Llosa (Chile) and Jorge Amado (Brazil) have had a tremendous influence on world literature over the past century. Borges in his fantastical stories opened up a whole new world to millions of readers worldwide. In many ways his fictions have become part of our modern culture. For example, the British writer Salman Rushdie introduced into some of his recent work several of Borges' invented books and characters as if they were real (Rollason, 1999). His novels illustrate the multiple stories of our lives. One story overlaps with another and the author himself is positioned in the text. There is so much in Borges' work for psychologists to study.

However, storytelling is not just the domain of the professional writer. Rather, we are all natural storytellers – we construct and reconstruct our worlds through the stories we exchange (Murray, 1997a, b). These stories are not simply spun out of

fantasy but engage with the social and material world in which we live.

The advent of serious illness is a crucial turning point in our lives that causes us to reflect upon our materiality and the transitory nature of our lives. The literary critic Anatole Broyard (1992) detailed his early response to the diagnosis of cancer:

My initial experience of illness was as a series of disconnected shocks, and my first instinct was to try to bring it under control by turning it into a narrative. Always in emergencies we invent narratives. We describe what is happening as if to confine the catastrophe. Storytelling seems to be a natural reaction to illness. People bleed stories and I've become a blood bank of them. (p. 21)

It is through these narratives that sick people define themselves and clarify their relationship with their bodies and with society. In this paper I want to discuss how narrative shapes our understanding of disease in everyday life.

According to narrative psychology the person begins to grasp the meaning of a crisis by creating a story about it (Bruner, 1987). A central belief in Western society is that our

lives have a form of linearity and continuity (Becker, 1997). A challenge to our expected organized storyline can lead to disorientation. The experience of illness represents a crisis for the patient and for their families. On initial diagnosis the individual can experience substantial existential dislocation. For example, in one study we conducted on women's choice of treatment for breast cancer (Dicks & Murray, 2000) we found that most of the women we interviewed reported that they felt numb, agitated and distressed when informed of the diagnosis. Indeed, when asked to recall details of the subsequent conversation with their physician most of the women could recall little. When the surgeons were later interviewed they reported that they always provided details of the different treatment to all their patients. However, the women did not recall any of these details. Instead they recalled what could be described as incidental details such as the colour of their shoes or what dress they were wearing. It was these images that they recalled. It would seem that the more traumatic the episode the more difficult it is to create a narrative account about it (cf. Kraft, 2003).

At the initial stage of diagnosis it is difficult for the patient to develop a narrative account. However, over time the patient begins to develop a personal narrative. Arthur Frank (1995) has argued that the desire to develop such a narrative by the patient

is a symptom of the postmodern era in which the more standard biomedical narrative is being challenged. It is not just the standard medical narrative that is being challenged by the stories constructed by patients but other popular myths about particular illnesses and diseases. In this paper I consider this and other characteristics of illness narratives through consideration of a selection of narrative accounts provided by women who had breast cancer.

Cancer stories

Breast cancer remains one of the most feared diseases for women in the western world striking as it often does at relatively early periods of the adult life cycle (Murray and McMillan, 1993). Despite substantial advances in the treatment of the disease it still has a high mortality rate for those women who are diagnosed at a late stage. Further, the medical and surgical treatment of the disease can lead physical disfigurement. There has been much research into how women cope with breast cancer but what does it mean in terms of their identity and their social relationships.

In a recent study, women who had had surgery for breast cancer at least one year previous were invited to discuss the experience. In general, the women were very keen to provide detailed narrative accounts. Indeed, the interviewer had merely to introduce the topic and then played a minimal role in the unfolding

conversation. There was an obvious desire to tell their stories. Indeed, many of the women mentioned that they had had little opportunity to talk about their cancer experiences since their family and friends wanted to, as it were, to return to normal as rapidly as possible.

Narrative analysis

Through their stories people define both themselves and their experience. In analyzing the narratives the aim is not to break them down into parts but to try to consider their integrative features. Such features include who is telling the story, how is the story structured, and what is the story trying to do. Further, the particular features of the various narratives gain their potency through connection with previous personal emotional experiences, interpersonal episodes, and their meshing with broader cultural narratives. Each of these features will be introduced later in this paper.

Narrative character

The narrative account revolves around a certain character or characters who are, in turn, defined by the narrative. Bruner (1987) places the character or cast of characters at the centre of the psychological narrative. We tell stories about someone. Central aspects of character are the extent to which they are defined as action centres in the sense that they are responsible for their actions and the nature of their beliefs and values. For example, to

what extent is the character in control of their own destinies or victims of fate. The character connects with the actions – he or she is an action centre. As the writer Henry James argued: “What is character but the determination of incident? What is incident but the illustration of character?”

Besides describing the characters through their actions and their beliefs, we also define the characters through their relationships with others. The characters in the narrative do not exist in themselves but in relation to others. For example, we can define a character as powerful by portraying other characters as weak or vice versa (see Jacobs, 2000).

The study of the narrative character is a central feature of narrative analysis. However, the character identified is not something fixed but emerges out of the engagement between the narrative and the analyst. The character does not simply reside in the story but also in the very analysis. It is through the analysis that the analyst identifies certain consistencies that form the basis of the inferred narrative character. Even when the individual attempts to diminish his distinctiveness the perceiver constructs a certain character. This does not mean that the analyst invents the character, but through careful exploration identifies consistencies in the narrative actions and relationships (Abbott, 2002).

It is through exploring these narrative features that we can begin to understand the character of sick individuals and, more specifically, how they react to disease. In this paper, I consider three character dimensions: womanhood, perceived control, and outlook on life in general.

Womanhood: *Mater versus Materia*

The central character in the breast cancer narratives is the woman telling the story. In Western society, representations of women vary along two primary dimensions defined by Nead (1992) as 'mater' (mother) and 'materia' (matter). In everyday life these two dimensions vary in their importance for women. Many of the women with breast cancer interviewed felt that motherhood was the central part of their identity. They defined themselves in reference to family life, children and their role in childcare.

Consider the case of Nina. In many ways she was not a traditional mother, nor had she experienced traditional family life. But it was these very differences or absences that drew attention to the centrality of motherhood. She was a fifty-year-old single mother. She described her upbringing as difficult. Her mother died when she was two and she and her siblings were sent to different orphanages. There they were very badly treated by the guardians. On leaving the orphanage Nina trained to be a nurse. She found it difficult to establish a secure relationship but

wanted to have children. She had three children by different partners but never married. Two of the children had grown up and left home. The third was aged twelve years. She had not held a full-time job for many years.

About ten years ago she had been diagnosed with breast cancer and had undergone surgery. She described her life as difficult and the diagnosis of cancer was considered to be devastating. It was not marriage and being a wife that Nina desired but rather motherhood and having children. At one stage she said: "So then when I had my children it was like, still no commitment. I just wanted a child and I got a child ...

And I went out and got another child because that's what I wanted and you know, so that's the way I did it."

She did not want a husband: "don't ever want to think of it, and just wants my kids and you know." Her experience of not having a mother when she was growing up and her desire to be a 'good' mother meant that she had to give up her job as a nurse when she had children since "my kids were more important and I didn't want them to be raised by somebody else like I was raised by somebody else". When she was receiving chemotherapy after having had surgery the main disruption was to her childcare, viz. "I had to get up, go have chemo and come home and look after three children and it was like wicked, wicked."

For Nina the actual experience and consequence of having breast cancer was patterned through this characterization of herself as a mother. The physical exhaustion following her chemotherapy was accentuated because of her childcare responsibilities. While the prospect of death was fearful she could handle it if she had the opportunity to fulfil her responsibilities as a mother.

Contrary to Nina, Jane played down the motherhood dimension. Jane was a 47 year old married woman with one young child whom she had adopted five years ago after finding she could not conceive because of fertility problems. Although she had one child, motherhood was not the defining characteristic of her identity. At on stage she said: "I figured I wasn't going to use my breasts *per se* (laughs) ... I've never had a child. We couldn't have one, so that was really sort of wasn't on the cards." Instead, Jane defined herself more in terms of her job as a senior executive. It was not surprising that she recalled that: "for some reason or another the thing that worried me or worries me was the possible loss of the use of my arm". It was her arm and her hands, not her breasts, that she identified as the essential parts of her body. Those were the bodily parts that she required to fulfill her working life.

The women referred less frequently to 'materia' or their bodies. This was an aspect that they preferred not to dwell upon. They would refer

to the absence of a breast in an off-hand manner. It often depended upon the perceived attitude of their husband. For example, another woman named Helen recalled:

It never bothered me cosmetically, the surgery. I never felt as far as my husband never ever made me feel inadequate or it never changed our relationship in any way. I always knew that he loved me. He never made me feel that way. It never bothered me ... The only thing I notice is that sometimes I watch television and sometimes I get preoccupied looking at women's breasts. If I see them in a curvy low cut dress I'll notice that I'm there thinking about it. I laugh about that.

This emphasis on *mater* and not on *materia* reflects the age profile of the women interviewed. They were mostly in their 40s and 50s. One woman named Lucy was only in her 30s. She felt a greater sense of physical loss. She recalled:

I got it [breast] off and instantly I felt like a little girl again. I really did because you don't have your breasts. I was like ... I felt like a little girl. ... You even look at yourself different. You look like a little girl.

Then she added: "but that passes. That goes. ... It doesn't bother me not to have breasts." Initially she was more conscious of her bodily

change: "I guess I just had more time to just focus on me. I was like ... I'd look in the mirror and go 'yuck.'" Once again it was the attitude of her husband that she found reassuring and helped her to accept her changed body.

Being a woman meant different things to these individuals. For most it meant being a mother and the horror of breast cancer centred on this threat to their motherhood. For the younger women, being a woman had more sexual connotations. For these women, the removal of their breasts threatened that aspect of their identity.

Perceived control: Fate versus free-will

Perceived control or personal self-efficacy is a central concept in models of personal identity (e.g. Bandura, 1996). In narratives, the central character often veers between being in control and being controlled by circumstances. General self-efficacy also overlaps with perceived control of disease. Some women with breast cancer that we interviewed had achieved much success in their lives but still were very self-deprecating and emphasised the role of luck or good fortune in their lives. Consider again the case of Jane. Life held many challenges for her but with hard work and good fortune it had been possible to overcome these. She held a senior position in government and at the time of diagnosis she was experiencing marital difficulties and was

considering separation. These difficulties had increased after her husband lost his job. Jane had been diagnosed with breast cancer about five years ago. She had undergone surgery and after a short period of sick leave she had returned to work.

Throughout her account Jane discussed her job in which she had been very successful. However, she was reluctant to attribute her successes to herself but rather frequently referred to her good fortune. This good fortune extended from her educational achievement through to her success in gaining her position. However, she did couple this repeated reference to good fortune with the admission that it also involved hard work. This image of the hard working but fortunate person was the character that pervaded the account. The fact that her husband had lost his job while she was achieving successes was disconcerting. To take all the credit for her own success would be in some way to blame him for his failings – it was better to consider her success as due to luck.

In terms of health Jane again emphasized her general good fortune: "I've been very lucky I had good health". Finding the cancer was in some ways good fortune too. She had gone to her physician after she had stubbed her toe. Her doctor thought that since she saw her so rarely she might as well do a complete physical and found the lump. When she was diagnosed as having breast cancer Jane

was shocked but took it in her stride. She initially had a lumpectomy followed a year later by another lumpectomy. However, on further investigation the surgeon decided to do a full mastectomy. Jane described this decision in very moderate tones. She felt having cancer was a matter of chance. It was something that happened and which with the help of good medicine and determination on her part she would recover.

She said at one stage: "People have described me as being ... not getting too excited over things, and I think I handle stress reasonably well. And when I do get to the stage where it gets to me, I can have a bit of a short temper but I hide it in most places." The characterization of self as a lucky character but one who handled life crises in a matter-of-fact manner permeated this narrative. In many ways, life was a job that had to be worked at. She was a good worker and destiny had generally been good to her.

The role of fate and chance in people's lives pervaded many of the narrative accounts. It contributed to a certain acceptance not only of good fortune but also of adversity. Cancer was something that happened – it was the way of the world. There was no need for an extended search for meaning. It did not mean that you relented when faced with adversity, rather you attempted to combat the challenge. In Herzlich's (1974) terms

the disease was something to be worked at.

Outlook on life: Optimism versus pessimism

Within the literature on psychosocial oncology perhaps one of the most researched personality dimensions has been that of perceived optimism (e.g. Murray and McMillan, 1992). Several of the women with breast cancer referred specifically to the general positive attitude they had to life's challenges. Thus while they may have experienced various adversities, they felt that they had overcome these partly through adopting a positive attitude. Consider the case of Bonnie, a 52 years old woman. She had two siblings and felt that her childhood had been happy: "We're from a very united family. We were all very close ... We were always a close, happy family". Bonnie trained as a nurse but after she had children she became a full-time mother. She had two children who she described as "happy, healthy children." Her husband was a surgeon. Not surprisingly, she frequently used medical language in her description of cancer. At one stage she confided in her belief in the power of medicine, although even then she qualified that by referring to the need to adopt a positive attitude: "I suppose I have faith in medicine anyway. There's so many people out there doing research that everyday there's new drugs ... new treatments that we have to be optimistic."

Throughout her narrative she emphasized the positive outlook that pervaded her life. She contrasted her stance with the frequently depressing events that occur in everyday life:

I'm very positive about life. I'm a positive person anyway. I tend to look on the bright side and hope for the best. I try to see the best in everything really. It's the only way. Otherwise, like I've said earlier, there's lots of doom and gloom out there. Try not to look at it, focus on the positive.

When she was diagnosed with breast cancer this outlook came into play: "I always feel that it is important to have a positive outlook. So that's how I faced breast cancer. I'm going to do the best I can and be positive." This positive attitude extended to how she conveyed her reaction to cancer to her family and friends. She felt that despite shock and fear she had to convey an upbeat image:

I know that the day I was diagnosed when I came home my sister-in-law called and when I gave her the news, of course, she was so upset she started to cry and I became very emotional but I thought I can't talk now, I can't cry because my son was writing an exam that night and I didn't want to let him know.

Looking back, she adopted a bravado attitude. Cancer was something that had happened but now

she must move on with her life. She said: "it happened and I'm doing OK. It was rough but I made it through."

Implicit in this general positive attitude was the belief that other people had a more negative attitude but because of her family responsibilities she had to keep going. She could not let the cancer adversely affect her family life. Other women also articulated this viewpoint. Consider the case of Lucy. She was pregnant with her first child when she was diagnosed with breast cancer and had a radical mastectomy before the child was born. She recalled:

when I was going through it I was too busy to think about anything negative because like I said I was taking care of, trying to take care of, myself and a brand new baby. ... I just had that mindset that I'm going to be OK because I have to be now that I'm a mother.

Similarly, Helen recalled that because of her husband she had to be positive and upbeat:

Well my husband was totally devastated. I think that's what really helped me so much ... I had to play the reverse role. Because he was so devastated I felt I couldn't be.

These three character dimensions were pervasive in the women's narrative accounts. In many ways they were complementary. While the women might feel that they were the subjects of fate they could

manage by having a positive attitude. Thus rather than struggling with the 'why me?' question, many women adopted an acceptance of the disease. This orientation in their narrative accounts was developed after the event. The women frequently reported that initially they were shocked but then they began to develop a more integrative narrative.

The narrative accounts are developed looking back on the event. It is through adopting this perspective that the women can actually begin to transform the experience narratively. As Hilda said about her life after cancer:

Well, I see the value of it more. I mean when you are staring in the face of life and death you realize how precious life is and you go for it. Like, I'm lucky. I'm lucky I've got everything I've got. And I realize that. Whereas before you'd take a lot for granted but I know ... you know ... I'm very lucky. And I love it [life] more because of that.

This attitude provided a sense of closure to the narrative and enabled the woman to put the cancer behind her.

Narrative structure or Genre

While analysis of these character dimensions provide insight into the experience of having breast cancer they are in turn bounded by the structure of the narrative. The genre

refers to the overall structure of the narrative. There have been many attempts to describe the basic structure of narratives. A popular formulation is that developed by the literary critic Frye (1957) who argued that the four basic genres underlying Western literature were the tragedy, the romance, the comedy and the satire. In the tragedy, the hero struggles against adversity but ultimately fails. Conversely, in the romance the hero initially encounters resistance to achieving certain goals but through persistence eventually succeeds. In the comedy, the hero engages in an ongoing sequence of change. Finally, in the satire, the hero is considered from a position of detachment as an almost comic figure and victim of circumstance.

This classification is a useful heuristic device for organizing literary works but its application to everyday narratives must be considered with caution. In everyday narratives the genre can shift from one form to another and back again. This shift can characterize certain crises or turning points in the narrative. As Jacobs (2000: 29) has argued: "crisis gets its dramatic power from the tension between competing genres".

Again, the structure is not something that simply resides in the narrative but rather is a strategy used by the analyst to systematize the detail of the plot. Indeed, in some ways it is similar to Ricoeur's definition of

narrative: it is a means of bringing order to disorder.

Genre I: *Tragedy*

In terms of narrative structure or genre Nina's story contains the movement from romance to tragedy. Her whole life had been difficult but she had managed to overcome many challenges and to find personal fulfillment through having children. This was a major achievement of which she was proud. However, the diagnosis of cancer seemed to turn this right around. Life has been an ongoing struggle. Initially she met with some successes but now she was uncertain about what the future held. This turn from one form of narrative to another highlighted the impact of cancer.

This narrative can be divided into three clear phases. The first phase had the classic romantic characteristics. It began with a period of difficulty followed by struggle and limited transcendence as she freed herself from her early childhood difficulties and began to define herself as an independent woman. The middle phase was the diagnosis and treatment of cancer. The actual detail of the cancer diagnosis and treatment was described as happening very quickly: "She sent me to Dr. Smith and Dr. Smith said this is what it is right. And before I knew it, like I say, I was in hospital and the next day was the operation and the next day I was awake and somebody was saying now

we're going to start chemo. And, you know, it was happening just so quick, you know." This speed of occurrence accentuated the crisis: "like it really flipped me right out ... I cried for three weeks".

The third phase had many of the elements of tragedy. After so many hopes and limited successes there beckoned a period of decline. However, she was able to limit this decline by highlighting the success. Now that her children were getting older Nina was less concerned about the cancer. She had fulfilled her duty as a good mother: "if it happens again I would sort of say well I got my children raised and they're going to do good; they learned a lot from me – that sort of thing." However, that's in a few years time: "if it happens tomorrow and he's only twelve I will flip, I will really go crazy ... because what's going to happen to him ... welfare would come and take him, always worry about all that kind of stuff." So she was balancing on the edge of tragedy. The threat of the recurrence of cancer was a constant fear in her life.

Genre II: *Comedy*

The structure of Jane's narrative was more of a comedy. She had described her past as a mixture of hard work and good fortune. The emphasis on good fortune is typical of the central character in the comedy. She had had difficulties but had overcome these, partly through good fortune. Life was

a series of challenges and successes. If you worked hard you could succeed. So far, she had achieved a lot and did not expect cancer would end it. Instead she put cancer behind her and got on with dealing with new challenges. "It happened. There is no sense in crying over spilt milk".

The central part of her narrative account was the diagnosis and treatment of the cancer. Admittedly this caused some considerable disruption, but as with the many challenges she faced at work these could be overcome. As she stated: "There's been so much advancement, particularly in this type of cancer, that I really feel even if, even something else was found it could be handled".

Now that she had been successfully treated for cancer she could move on with her life. This sense of control over the disease was reflected in the absence of a dramatic turn in the narrative account. Despite this Jane was cautious about the future. As she said:

I think that you ... at least me anyway ... I'm almost at my most vulnerable when I think I'm through something. It's like I've done it. I've made it but I don't think you feel you've got the reserve to handle anything else.

In this sense the narrative was ended but there was no sense of closure. There was always the possibility of the cancer returning.

Genre III: *Romance*

Lucy's narrative account was similar to Frye's romance. Although cancer was a major challenge she had transformed this into an opportunity for growth. In some ways, her narrative was one of liberation. The very experience of disease had strengthened her. At one stage she said:

I think I've grown up a lot. Things that I placed a lot of importance on before I don't now. You know ... looks and ... oh god ... I don't know ... not so much material things because its not like I'm Rockefeller or anything ... but it's just a whole focus of, you know ... I know someday ... like I'm not immortal or anything. I'm going to pass on some day. I know that and I can deal with it. I'm not afraid. That changed. I came to that realization. And, like I said, just how you perceive yourself. Like you don't need breasts to be a woman. I've matured that way, I guess ... juts my whole outlook on life, you know. You go for life, you don't go for the other way. There's no point. So I'm just happy. I'm a happy person.

These three basic narrative genres can also be seen as variations on the three-fold narrative structure suggested by Gergen and Gergen (1986). The tragedy was similar to the idea of a regressive story but one that was un-ending. The comedy is a story of stability but requires a steady

commitment to maintenance of self. The romantic story in many ways promised a progressive narrative. In the narrative accounts provided there was often a turn from one genre to another that served to emphasize the crisis.

This turn in the narrative account could also be associated with a form of awakening or an epiphany by which is meant that the patient reflects broadly on life. However, for many women with breast cancer there was no sudden epiphany but rather a gradual reassessment of life's chances. This gradual reassessment is similar to Frank's (1995) concept of cumulative epiphanies. For example, in the case of Jane, it was only after the treatment had finished that she began to reflect on her life:

You start to think about the meaning of life and why you're here and ... you know ... is there some reason and what are you going to leave behind you ... I think about how life is evolving. Are we as ... are humans getting any better than they used to be or are they getting worse ... or ... you know ... those things are more ... more prominent in my thoughts than they had been before, I guess.

It is the prospect of death that encourages this reassessment of life. This reassessment through narrative has been termed a 'resurrective' practice (Seale, 2000). It is a means of

re-imposing life where there has been the prospect of death. This practice is central to the everyday work of narrative.

Work of narrative

Normalizing events

Narrative is not simply concerned with describing an event or series of events. A primary function is to give meaning to events through organization and systematization. It is through this process that events can be grasped and understood and integrated into everyday experience. There are two primary processes in this rhetoric of narrative: the linking together of events into a causal chain and the normalizing of events (Abbott, 2002).

The identification of a causal chain helps restore order to a world that has been disrupted. However, the onset of a disease such as cancer can sometimes evade the identification of a single cause. Indeed, the person can feel that it is undeserved morally in the sense that they had led a good life (see Murray, 1997). For example, consider the case of Bonnie. She felt that she was basically a good person: "I was always aware of the feelings of others. I always tried to please people. I didn't go out of my way to cause trouble." As such she did not deserve and did not expect the diagnosis: "I never really thought about having any health problems. So it's a kind of shock ... when you're diagnosed".

This sense of shock is often followed by attempts to integrate and normalize the news rather than to continue with the causal search. For example, Bonnie recalled: "I think you accept it and try to deal with it the best you can because what else can you do?" Other women referred specifically to the limited initial causal search or even to self-blame. For example, Helen recalled: "I never ever had the feeling of 'why me?' or I almost thought that I deserved it. I don't know why." [Really? Why do you think that is?] "I don't know. I just sort of felt ... you know ... well ... this is given to me so I'll have to make the best of it."

This process of integration and acceptance continues throughout the treatment of the disease. Afterwards, some felt that they could put it behind them. As Bonnie said: "I was really positive when it was over that I was getting on. It's all over. I was putting it in the past but unfortunately the opposite effect happened and I became depressed." However, she continued to work against the disease, in her words: "It's sort of been an up and down battle since chemo but I'm happy to say that things have finally straightened themselves out." Now she can say: "But anyway, it happened and I'm doing OK now. It was rough but I made it through."

The process of normalization and acceptance can be difficult not least because other people are often unaware of what the survivor has been

through. In Goffman's (1964) terms, the disease is concealable and thus the woman can pass. Bonnie referred to this problem: "I think, well when people who see someone who looks so perfectly well and whatnot they can't imagine that you actually have breast cancer."

For some patients, particularly those with chronic or life-threatening diseases, the process of normalization however is never fully finished or successful. The patients are changed by the disease and, in the case of cancer, there is always the prospect of recurrence. As Bonnie said: "You don't look six years down the road or two years down the road. You tend to take life for the present and hope that you're going to be a lucky person and live a full life."

These narrative accounts do not have closure in the sense that they can be forgotten about. Indeed, the attempt to narratively put cancer behind them is sometimes challenged by the identification of new symptoms or news about a friend or a colleague, As Helen said: "I do worry. If I see things on TV I'm always thinking or if I get aches and pains I think 'oh gosh, is it back?'"

Biographical work

The narratives reflect the different experiences of the women and their efforts to integrate the cancer experience into their broader life story.

This process has been termed biographical work (Bury, 1982). For Nina her life story was one of woe and

one of the few achievements was her children to whom she was devoted. The onset of cancer was a major threat to her role as a mother and reinforced the negative life story. For Jane life was a series of hurdles that she could overcome. The advent of cancer was portrayed as yet another hurdle - with persistence and medical assistance she could proceed to the next hurdle.

A feature of this and other studies was the eagerness of the women to tell their stories. A prime reason why women with breast cancer join support groups is that it provides them with an opportunity for biographical work through sharing their stories (Yaskowich and Stam, 2003). Through discussion with their peers they are able to sort out their changed identity. This opportunity for biographical work is often restricted with their family members who have themselves been burdened with the crisis surrounding the disease and want to 'move on'. In the interviews, this lack of opportunity for biographical work was a common issue raised by the women and, indeed, was one of the reasons why they found the research interview in many ways therapeutic.

Arthur Frank (1995) began his discussion of storytelling by sick people with the phrase "The stories that ill people tell come out of their bodies". They come out of bodies that have undergone substantial change due to the very fact that they have had or still have disease and may have

undergone major surgery that has changed the physical appearance of their bodies. It is through publicly narrating their story about that disease and the surgery that the sick person can begin to redefine herself as a new person. For many survivors this can be a very difficult and challenging task. A particular challenge is the very choice of words and the sympathetic audience. For example, Jane stated: "I'm not very good with words when it comes to ... sort of ... describing how you feel. I think when you hear something like this ... I was fine when I was with a doctor. I had a hard time telling anybody else." Thus the opportunity for the public narration of their changed identity is an essential part of redefining themselves but it is an opportunity that many sick individuals find difficult to obtain. When talking with a physician the women who had breast cancer could comfortably use medical discourse. But this dispassionate scientific language did not enable them to convey their changed identity. The language needed to describe their new identity was not accessible and instead many of the women found that when they could not tell their stories they were confined to silence.

Narrative context

Narratives are told within a particular context the character of which needs to be considered to explore further their meanings. There are different ways of considering the context (see Murray, 2003a, b). Here, I consider the

personal, the interpersonal and the societal contexts.

Personal context

During our socialization we learn to attach emotional value to different events and experiences. One way of exploring the personal context of narrative accounts is by considering their emotional bases (cf. Hollway and Jefferson, 2000). In the case of Nina the experience of growing up in an orphanage added particular emotional associations to the presence and absence of family life. She and her siblings had made substantial effort to re-establish those family relationships that they had lost when they were separated in childhood, "we're always calling each other and sending each other a card and so on and so forth". She lost her mother when she was young. She did not want this to happen to her own children. Her fear of cancer was intertwined with this fear of history repeating itself for her children.

In the case of Jane, life was a series of good fortunes and she felt that she should enjoy these. Indeed, she made explicit reference to the advice her father gave her: "That was one of the things my father said to me one day. He said, 'life is meant to be enjoyed, not endured' and it's really stuck with me because I think it hit a cord with me. Something I really believe myself." The diagnosis of cancer should not be perceived as a threat to this basic optimistic

framework. Rather with determination and good treatment it could be overcome.

Interpersonal context

The narrative is told to someone else – there is always either a listener or an assumed listener. In telling her story, the narrator selects certain events to focus on and ignores or underplays others. This occurs in the interview as much as in everyday social interaction. For example, Jane was very successful in business. Despite this she felt uncomfortable talking about her successes. She was talking to a young female interviewer who was just starting out in her career. At one stage Jane said: "I must say I find it difficult talking about myself. Umm ... I don't know what to say." By emphasizing her good luck she is reducing any power imbalance between her and the interviewer. In addition, this constant reference to luck was a way for this woman to deal with success in a male dominated world (cf. Deaux & Emswiller, 1974). She had been promoted ahead of her male colleagues but felt that she "couldn't understand this." Also, she had survived cancer and returned to work speedily. She preferred to underestimate her own role in the recovery. Breast cancer was just some misfortune; it was nothing special. She had been able to overcome it with luck, persistence and the assistance of medical science.

Societal context

Finally, the personal narrative accounts mesh with the broader social narratives or myths about particular diseases. Several Brazilian social psychologists have made substantial contributions to our understanding of this societal sphere. For example, Mary-Jane Paris Spink (1999) has argued that making sense of illness events is “a process that integrates two levels of socially constructed contents: the collective level associated with the circulation of ideas and socially instituted practices, and the inter-subjective level of dialogic interchanges in of daily life”. Jovchelovitch (1999) has considered the political narratives that shape everyday practices.

Here, I consider three social narratives about cancer:

1. *the recovery myth*: this is the belief that breast cancer is just another event in a woman’s life that with a certain amount of willpower she should be able to get over and move on. Although Bonnie had great faith in the power of medicine she was still somewhat apprehensive about the future: “When you know you’ve had any type of major illness you’re thankful for good health, so you tend to ... well I do anyway. I take one day at a time. And I try to be very happy that I’m healthy.” Cancer was not something that could easily be

left behind. Rather the prospect of it recurring was something that the women still carried with them. In that sense their narrative accounts were often open-ended and the source of recurrent anxiety. Despite this fear of recurrence the women felt they had to continue as normal. The widespread prevalence of the recovery myth led many women to conceal their anxiety. It was not something that they felt comfortable continuing to talk about. After a certain period had passed they were expected to continue but this did not mean that the fear of cancer was gone. As Helen said: “It’s always there in the back of my mind.”

2. *the hero myth*: the belief that those who survive adversity are implicitly heroes. Jane’s narrative account deliberately tried to subvert this myth by emphasizing the everyday mundane storyline of her recovery. Indeed, none of the women we interviewed accepted such an overtly heroic storyline. Rather they preferred what could be described as the unassuming or quiet hero image. In many ways they were proud of themselves but it was not something they wanted to boast about. Cancer was an unwelcome visitor and whilst it

had been vanquished, the women felt that to boast about it may attract retaliation. They were cancer survivors, not victors and there was always the possibility of its recurrence.

3. *The victim myth*: the converse of the hero myth is that a survivor of cancer is a person who has lost so much that they are in a constant state of misery. Many of the women resented this viewpoint. For example Lucy said: "I'm right into the swing of things again. I feel fantastic about it all. So for me it wasn't a terrible thing. You know. All of it. It wasn't a terrible thing. I'm not making light of it but in my opinion I have no choice but to look on the up side. Look towards life because there is no other side. That's just the way I looked at it and that's the way I still look at it. So I'm ... you know ... I mean I have people say to me "Oh my god, you poor thing. You've been through so much. I'm praying for you. . I'm like, you know, I'm OK. Until they tell me I'm not, I'm OK." So women felt tossed between these competing

myths. On the one hand they were expected to get over it and on the other they were expected to be broken and changed. In their everyday social interaction the women were aware of these different expectations and could adjust their narrative accounts accordingly.

Ongoing narrative discussions

The rapid growth of narrative research within health psychology provides an opportunity for a more detailed understanding of the illness experience. Analysis of narrative accounts attempts to consider the whole structure rather than breaking it down into parts. In this paper we have considered some central features of narrative accounts: the character of the narrator, the narrative structure, the work of narrative and the context of the narrative account. Each of these provides additional insight into the experience of illness. These characteristics of narrative were considered since they provided the best insight into the experience of breast cancer. Other narrative characteristics may provide greater insight into other disease experiences.

CHAPTER 10

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).

The third account, entitled *Dying to Live*, is by Georgia Comfort, a pianist from the mid-west of America. At the time of her initial diagnosis she was in her late thirties. She was married with three sons, the youngest of whom was about to start school. Georgia and her husband are both very strong Christians. This religious fervour forms a central theme of her book. The initial cancer of her breast

was detected when she was aged 38. Georgia had a mastectomy but follow-up detected cancer in the other breast. She underwent another mastectomy this time coupled with double breast reconstruction since, as she said, "at age thirty eight I felt I was too young to be flat-chested for the rest of my life. I wanted my body to have some feminine curves" (p.12).

A subsequent follow up a few months later found that the cancer had spread to the lymph nodes. She underwent intense radiation therapy which failed to halt the spread of cancer. At first Georgia was despondent but she drew inspiration from the Bible. She agreed to undergo bone marrow transplant treatment. This was a time of intense prayer by Georgia, her husband, and her friends. The bone marrow transplant was a success.

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, catalogues 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, 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), she asked.

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, 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. (p.)

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 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, it's 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 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 11

NARRATIVE ACCOUNTS OF INJURY

Introduction

Commercial fishing is one of the most dangerous occupations in the world. Mortality data from a range of countries confirm the worldwide nature of this problem. For example, the fatality rate in the US fishing industry is 160 per 100,000 which is 25–30 times the national average, and in Australia the rate is 163 per 100,000 or 18 times the national rate. The rates are also higher than in other natural resource-based industries. For example, in the United Kingdom the fatality rate in the fisheries was 77 per 100,000 as opposed to 23 per 100,000 in the mining and quarrying industry [22]. Despite measures to improve safety on fishing vessels, large numbers of fish harvesters continue to be injured or killed in the industry every year. The injuries range from the commonplace cuts and bruises to more serious events including broken bones, damage to the spine and nervous system and loss of limbs [14]. Those who are seriously injured have little prospect of alternative employment since they often live in small isolated fishing communities.

Researchers have explored the experiences of injured workers in many other industries. However, they have tended to consider the experiences of workers in general

rather than connect them with the characteristics of particular industries. For example, Stone [21] conducted interviews with injured workers in Northern Ontario. For these injured workers, work was a central aspect of their identities. The loss of employment due to injury had a devastating impact on their sense of identity and well-being.

In another comparable study, Kirsch and McKee [8] conducted a qualitative participatory research project with seriously injured workers in Ontario. They did not distinguish the type of industry in which the workers had been employed. Once again, the researchers found evidence of substantial financial, emotional and physical hardship experienced by the workers following the injury. However, while work and the loss of work may have common features, there are many features specific to any industry.

Fishing has many particular characteristics. The fishery that occurs in the waters around Newfoundland accounts for approximately one quarter of commercial fishing in Canada. In that province there are two main types of fishing: the large boat deep-sea fishery and the small boat inshore fishery. The former has some characteristics of a more routine

industrial occupation with the crew being employees of the ship owner, and they work year round. The latter often work in boats owned by themselves or their family members, and their work is more seasonal. One common characteristic is that the fish harvesters are drawn from small and often isolated communities that have a long history of involvement in the industry. Many of the fish harvesters have been employed in the industry from an early age and many have limited experience of work in other industries or indeed outside their immediate community. This background fosters a very close attachment to the industry such that any dislocation in their connection to it can be devastating [2]. These factors need to be considered in understanding the reaction of fish harvesters to disability.

Fish harvesters are proud of their work [15]. Previous research explored the type of identity revealed in their narrative accounts of fishing accidents [11]. It showed that fish harvesters defined themselves in terms of strength and industry but also in terms of danger and risk. Serious injury would be expected to have a negative impact on this identity as well as on the various social relationships of fish harvesters. For example, Murray [?] detailed the often conflictual dealings of injured fish harvesters with staff of the workers' compensation system. However, the impact of injury and disability on the everyday lives of fish harvesters

remains unclear. This paper considers the various reactions of fish harvesters to injury and disability as revealed through a study of their narrative accounts of the experience.

According to narrative psychology, narrative construction is an intrinsic part of making sense of the world [20]. The process of creating a narrative enables the person to give meaning to a crisis. Before the narrative there is merely a disjointed sequence of events. In creating the narrative the person selects some pieces of information and ignores others and pieces a story together. Admittedly this process is not conducted in isolation but as part of a wider process of social engagement.

Researchers have used a narrative framework to explore people's reactions to illness. Using this frame work it is possible to explore not only the changing experience of illness, but also the character of the sick person's identity and the cultural narratives drawn upon in shaping that identity. The onset of serious illness has been characterized by Bury [3] as a period of biographical disruption. In his study of people with rheumatoid arthritis (RA) Bury found that the disease disrupted their plans and hopes for the future. For these people their life-story no longer fit their everyday experiences and it needed to be recast. This process of reworking the parameters of the self was termed narrative reconstruction by Williams [23]. Again working with people

suffering from RA, Williams identified a pattern in the causal reasoning adopted by these individuals. They were attempting to integrate RA into their life plans. According to Williams, this process of narrative reconstruction helped the sufferers “reconstitute and repair ruptures between body, self, and world by linking and interpreting different aspects of biography in order to realign present and past and self and society” (p. 197).

A study of people with cancer found that their narratives were structured around three major themes: disrupted feelings of fit, renegotiating identity and biographical work [9]. The biographical work centered on the process of integrating the illness events into the larger narrative identity. A challenge faced by the cancer patient is that they feel rejected by their peers because of the social and moral stigma still attached to cancer. In this context they are deprived of the conversations within which they can conduct their biographical work. One place that provides a forum for narrating their changing stories is support groups. A study of the talk within these groups [24] found that it often centered on such biographical work. The patients spoke of their lives being changed and their attempts to get their lives back together. This body of research suggests that a study of the character of the narrative accounts of fish harvesters of their experience of disability will increase our

understanding of how they manage this change in their lives.

Collecting stories

The accounts were taken from a qualitative study of fish harvesters conducted in Newfoundland, Canada [16]. That study was part of a larger project concerned with accidents and safety in the fishing industry and had the support of various partners including the fish harvesters’ union and the local workers’ compensation system.

The workers’ compensation system identified from their records a total of 206 fish harvesters who were currently receiving extended earnings loss benefits due to injury. These benefits are available to injured workers who are unable to re-enter the workforce or are unable to earn as much as they earned before their injury. A letter was sent from the compensation system to these individuals inviting them to participate in the study. A total of 35 fish harvesters replied indicating that they were interested in the study and of these individuals 26 participants were contacted and interviewed. The participants were drawn from both the in-shore (N = 11) and the deep-sea (N = 15) fishery. They ranged in age from 46 to 61 years and had been disabled from 4–23 years prior to the interview. All but two of those interviewed were male.

Individual interviews were held with the fish harvesters in their own homes. The interview approach

adopted the biographical or life-history format [12] such that participants were initially invited to describe their entry into the fishing industry, their experiences of being a fish harvester, the accident or accidents, the impact of the consequent injury on their everyday lives, their dealings with support services, and their overall thoughts on fishing and safety. Throughout a conversational style was adopted. All of the interviews were tape-recorded and subsequently transcribed for analysis.

The interviews transcripts were then read for their underlying narrative orientation [10]. The aim of this analysis was to identify variations in the overall reaction of the fish harvesters to the disability and how they attempted to integrate the disability into their everyday lives and to redefine their identities. Four primary narrative orientations in the accounts of the fish harvesters were identified. Each of these narrative orientations is described along with a detailed example of this form of narrative. The extracts from the interviews have been edited to remove any repetition or incoherence.

Types of story

Disability as Devastation: This narrative orientation typified the accounts of those fish harvesters who felt that their lives had been ruined by their injury. Although many of the fish harvesters' accounts had this orientation, it was particularly

apparent in the accounts of those with limited experience outside their community and outside the fishing industry.

Example: Red

Red was 52 years old when interviewed. He had lived in a small fishing community all his life. He is married with two grown-up sons who have now left home. His wife works in a local fish plant. After fishing for over 30 years in the in-shore fishery he tripped on the wharf and seriously wrenched his body. He has not worked for four years. His narrative account emphasized his close attachment to the industry and the devastation he experienced when he found out he could not return to it. Being a fisherman was central to his being and the onset of disability was described in terms of devastation. He defined himself as a fish harvester who he believed was generally honest and hard-working. He resented the image of the fish harvester as lazy:

A lot of people don't know about the fishery – a lot of people. They're very ... ignorant to the fact that they don't do anything in the wintertime, only jump on their skidoo ... or on an ATV [all-terrain vehicle]. I'm after getting that said at me where I have to turn around and not letting them know that you was angry and giving them a good sharp answer [...] We owns our home. But we worked

real hard for that [...] People don't understand about the fishermen.

Like many injured fish harvesters Red had a vivid recollection of his accident:

The injury happened July 31, 2000. I was into a store or the fish stage – and I was packing nets in the stage and [...] I pitched on the floor. I've got all this here now – the muscles are all tore up there [...] everything just went. I had the nets on my shoulder. And I hooked the toe [...] because there were more nets there ... and I was stacking them.

At first he did not realize the extent of his injury and was devastated when he was advised by his physician that he could not return to work:

When he told me [...] he said to me, "Red", he said, "there's no more fishing for you". Now how would you feel if you told you now, you ain't got a job tomorrow and you was at that job a long time? It wouldn't feel ... very good, would it? [...] The trauma from it [...] hit us pretty hard. I just more or less lost everything because that was my way of life [...] it's a hard job for a way to describe it. Like you lost a part of you, but I wouldn't let go. Two years – really, a hard, hard time.

Fishing was central to his way of life. Without the opportunity to participate in the fishery he felt that his identity was destroyed:

He told me at the time I can't go fishing no more. So this was all I knowed was fishing. I even said to my wife – that's the only thing I know [...] I could not accept it. And I still can't. You didn't hear the first Newfoundlander say, it's in my blood and it's the heart and bottom of the soul [...] that hit me pretty hard too.

There followed a long period of rehabilitation. One particular source of frustration was the insinuation by some neighbors and professionals that his disability was partly psychological or that he was malingering. Now he was beginning to adjust to life without fishing but the impact was still devastating:

It's a feeling that will not leave it. It's still with us now. It took me two year ... three year for to make it clear in my mind that I wasn't going back fishing. You know, it's always there. You know, the day is coming – I'm getting back in my boat again, eh, because I want to get back in the boat. That's what I love.

A particular turning point for Red was selling his boat:

I sold the boat, yeah. Well, I couldn't hold onto her because I couldn't meet the payments so it's almost just as well to say

that she was taken. Oh, man oh man, when that boat went out through that harbor out there, that's where my soul went. I thought a lot about the boat, right. That was bad. [...] I mean to say, you know, a nervous breakdown for a long time. I [would] come out and ... sit there. What's you going to do? I got no gear to do; I got no lobster traps there to fix; I got no lump. I got no crab pots for that for to do.

He tried hard to consider different options for his life but was constantly reminded of his loss by the work of other fish harvesters in his community:

I tried to keep going ... If you never had no depression yourself... you don't know what it's like.

There's no other feeling so bad ever in this world. I lost everything. The first two year when they told me that what I just told you – something snapped and that was it. I almost lost touch with reality. Anything that you're doing was almost like you couldn't feel any good. If you went for a walk ... you went ... and coming back, usually you be relaxed, wouldn't you? No, no. You know, it didn't do me any good [...] I couldn't take it down that I had to knock off fishing and seeing other boats going out

and then when they come in, you're out on the wharf, eh.

He still defines himself as a fisherman:

Well, I got to accept it. I'm gone to the point now, that this year now, I mean to say, I'm still not accepting it but it's a hard job for me to tell you how to explain it. I mean to say, the fishing will never ever leave me. Some ask what do you do. I says I'm a fisherman. And, I mean to say, I never fished since 1990, go nowhere four year, right. But, you know, I say I'm a fisherman.

Disability as challenge

This narrative orientation was apparent in the accounts of those fish harvesters who adopted a more pragmatic approach to the disability. It was something that they dealt with on a daily basis. They were still working through the impact of the disability on their lives and often sought to somehow return to the industry, even on a part-time basis. This orientation was typical of those with alternative work experiences.

Example: Bernard

Bernard is a 61 year old inshore fisherman. He started fishing when he was 11 years old, fished for about six years and then moved to Ontario where he married and had three children. When he returned home in his 30s he started fishing again. He was injured about four years ago.

Despite pain and restricted bodily movement he insisted on returning to a limited fishing after about a year on full-time disability. He hired an assistant and now fishes part-time. This account again illustrates the very strong attachment of the inshore fisherman to his work. Even after he was injured, Bernard took steps to return to the fishery part-time. Although he was active in the community, the idea of not participating in the fishery was unacceptable. He defined himself as a fisherman and felt very frustrated at the restrictions imposed by his disability. The injury posed a challenge that he worked hard to overcome. This was an ongoing process.

Bernard left school early and began work in the fishing industry. He recalled the excitement of those early days: "Oh, loved it! There was nothing better. We were free. We did our own thing. We had no problems, unlike we got today." He then left the fishing to take work in the city but the lure of the sea persuaded him to return with his wife and children fifteen years later. Then four years ago he had a serious accident. Like many fish harvesters he blamed the pressure of work in the industry:

When I had my accident I had crab pots in the water and I was loading ice to go and haul my crab pots, and what happened – some of the ice, as I was loading and shoveling it aboard the boat, some of it got onto the rail

of the boat and when I climbed down over the wharf to get aboard my boat, I put my foot on the gunnel of the boat – and that's when I slipped and my boat is only about 3 feet from the gunnel to the base of the boat, right; but nevertheless, when I stepped, one foot went into a pan of ice and the other one landed on the bottom of the boat and that threw my back out, you see and I've been shagged up ever since.

He stopped working for about a year but longed to get back to work. Despite his disability he worked out a way to return to fishing part-time with a hired assistant who did the heavy-lifting work:

I went back– just lobster fishing only. I discussed it with the department [workers' compensation] that I wanted to go back to work. First, they offered me this money up until I turned 65. I said I would like to go back to work. They said, well, it's was up to me. But they were fair. They said, "Now look, if you goes back and you can't do it, you come back to us." I appreciate that, even though they give me a bit of a hard time at the beginning. The only thing I can do now is lobsters and I had to hire someone to go with me, right.

Although he had been able to return to work, he still felt annoyed

that his earlier plans and investments would no longer be of any value:

I think my problem is – I've always been used to working hard. Nothing I done was easy. It's only in the last, we'll say, fifteen years or so we got the hydraulics to work; but everything was done by hand – and now we got top-of-the-line equipment, but it's no good to me. After all those years waiting to get that and ... when I got it, it's no good to me.

The feeling of being, in a way, a half-fisherman was frustrating but it was much better than not fishing at all:

I don't feel very good at all, but I knows if I'm not doing this, I'll probably end up in the mental because this is enough to drive you crazy. I'm used to working all my life and I finds it hard now. As I talk to you right now, I should be out in the fishing boat now. All the boys in the harbor are all out fishing. I'm in ... sitting in here looking out. You know, that's harder on you than anything [...] I sees them [friends] all the time, right ... and like you say, the hardest thing on me is watching someone do what I always did ... and here's the guys coming in and going and here – all you can do is look at them. That's the hardest thing I finds.

Like Red, the sight of other fish harvesters was a constant reminder of his loss:

I'm overlooking the harbor and looking at the fishermen doing what I enjoy doing and even as I speak to you today ... I still have no intention of giving up lobster fishing. I'm going to stay at it until there's no one [...] I kind of want to stay fishing until someone has to take me out of the boat and put me in a pine box. I say it's the only thing I know. It's in the blood.

Disability as phenomenon

This narrative orientation is a sub-category of disability as challenge. It typified the narrative accounts of those fish harvesters who adopted a controlled and distanced stance towards their disability. They were able to review their past and current life from a psychological distance and to carefully consider strategies for improving their future life prospects.

Example: Ken

Ken currently lives in a small community not far from the provincial capital. He was 41 years of age when interviewed. He is married but has no children. He had started out fishing when he was 16 years and was seriously injured twelve years later. He currently works as a part-time security worker. Ken graphically described the stages of adjustment to disability – from initial shock and

denial through anger, depression and finally some form of acceptance. Throughout, he was very analytic in his description of his reaction to the injury and his dealings with various support agencies. His injury was a phenomenon that he examined in detail: observing how it had impacted on his life and considering how he could address the various consequences.

Ken initially started working as a fish harvester on a small inshore boat but then after advanced training got a position on a deep-sea trawler. This was hard work but the money was good and he enjoyed that for almost ten years until he was injured. He vividly recalled the accident that led to his injury:

The day I got injured was July 10, 1990. Now it was rough. I remembers that [...] for some reason, he stopped the crane because the ship was probably going to take a roll and the same time I glanced behind, the water was coming in and I lost my footing and usually if you lost your footing, you're holding something - you can hold on. And when my feet gave out like that, I figured I'd go along, but I didn't. I came down - and the deck of the boat is steel, of course - and struck right on the tail bone; and when I went backwards, I struck on a partition that runs through the boat about 18 inches high and I

struck right there on it - right at the base of the skull.

Ken was able to adopt a rather detached stance toward his injury. Although it had occurred over twelve years ago he was still able to recall his reaction in some detail:

The thing is no matter how bad you're injured, I think you convince yourself this is only temporary; I'm going to be back on the job. First of all, when you find out that you're not going back ... I spent a lifetime working up to where I was and I was getting close to being skipper on one of those big ships and I never got skipper. I got right up to chief, but I never got skipper. Learning to accept something like that is absolutely terrible. It was terrible.

He broke his reaction down into stages similar to those identified in other studies of loss such as from losing one's job [7].

When you get off first, you're just, come on, get this over with; I want to get back to work. That's the type of attitude you got. Then after two years or three years and you find out that the system is slow - moves very slow. Then after three years you find out you're not going back, you wonder what in the hell am I going at now. Then you get into a state of anger. Then you get into a state of depression. Then you got to

have the perfect partner. If you don't, you're in trouble. I had a perfect family on both ends: my wife, her family, and my own family. I had support from both ends, but sometimes that's not enough. The first thing you got to do is accept it – that you're not going at it. I was five years – probably longer until I finally accepted it and said, I got to forget about it. Now when I go down on the waterfront, I look at those boats and, damn, I still want to go.

He looked back on his life at sea with yearning. Although he had recently obtained alternative employment he still felt the loss and frustration:

It's still there. It's in the blood and you're not going to change it, and I hate working on land, period. I hate getting in my truck and driving in to work and driving back home in the evenings. I want to get on a bloody boat and go! And then when you come in and the trip is over, aah, glad to be home. You got two or three weeks off or a month. Go and do as you please. That is the biggest thing as far as I'm concerned.

He was particularly irritated by the interruption to his planned career trajectory. He had undergone advanced training and was expecting to be the skipper of his own boat.

Instead, his prospects now, at best, were some menial routine job ashore:

Now I was trained to be a skipper on a goddam boat – 3000-ton ship. And ... they felt I could sit in a booth and do parking lot attendant. You mean to tell me that's fair! You mean to tell me I should've had to do that! And they feel that you could ...yes, you can manage or you can go down there and be cashier manager. Wouldn't you feel like that's a slap right across the face and get the hell out there and we're cutting you off anyway. That, to me, was so unfair.

Like many injured workers he spent a large amount of time dealing with the workers' compensation system. Once again, he adopted a very analytic approach to dealing with the system:

I'm very angry with the system but instead of fighting it tooth and nail now with anger, I take their legislation and I pick it apart and I find little things in there that benefit me – I tape all phone calls –every phone call I tape because one feller ... one guy phoned me one day and told me something and then he denied he phoned. Since that, I tape every phone call. If you phone me and I think it's important, I'll tape it.

He had now begun to redefine himself as someone with a disability:

My life has changed too. I don't know if I walked inside a doctor's door up until I was 33 years old, and I haven't been out since [laughs] It's a steady belt now back and forth to doctors ... all kinds of drugs. I'm on drugs all the time ... I'm trying to keep off it as much as possible because they're very addictive and they're very hard on your system but I only take them when I absolutely have to – when I got a job to get out of bed in the morning.

Disability as opportunity

This orientation was apparent in the narrative accounts of those fish harvesters who had begun to explore new opportunities as a result of their injury. This orientation was typical of older fish harvesters who accepted that return to the industry was not possible but that alternative non-work opportunities might be possible.

Example: George

George is 64 years of age. He left school when he was only 13 and shortly afterwards he went fishing. He then worked in various non-fishing marine jobs away from his home community before getting a job on a deep-sea trawler. He was injured several times on the trawlers but after surgery returned to work until the most serious injury prevented his return. He had married twice and has five sons and two daughters. He lives

with his second wife, a former nurse, and her son. George described the arduous nature of life on board a deep-sea trawler. Despite many injuries he had insisted on returning to work. His view of life as a fish harvester was rather prosaic:

I liked it, b'y. I enjoyed it. I mean, you know, I don't think I'd go back again now though. Well there wasn't too much else to do, really. We always made a fair dollar at it. Good money all the time, you know. So it was really a job; that was it. You know, it was a job.

His approach to his disability was to move on with his life and to begin to explore new opportunities. During his time on trawlers he had incurred many injuries. He felt that he was tough. He described his various injuries in a rather routine fashion:

That night we did shoot away when the door fell on me. It was really rough. I mean, if the mate and the skipper says we're going to shoot away, well, you're going to shoot away. But that's what happened that time – it was too rough; and when I got the door up where I could get at it, when the sea struck her to ... come right in over and the gelsin come out of her, right. I could've jumped overboard and got clear of it but then I'd have drowned so. But there was so much swell, the door come in over and the gelsin come out of

it and it squat me between the door and the rail.

Despite a series of injuries he insisted on returning to work after surgery:

So that's '76, and then they done the spinal fusion in '79 and it didn't help that much at all, right. So, anyway, that was very good. I was still off on compensation. So then they done the second spinal fusion in '84. So I was feeling very good. So I got a letter anyway to go back to work ... returned to go back to work, and the doctor said, he's an amazing man for to have two spinal fusions and want to go back to work. He said, that's not ... this is not right.

However, he eventually incurred some quite serious injuries. Now he did not foresee any prospect of returning to work and was keen to move on:

I didn't like it at all but it happened ... so you know that's that. I don't like to think about the past ... that's in the past; leave it there. And think about what I'm going to do tomorrow.

He had begun to make adjustments to his life and to overcome the various limitations:

They said you could be in a wheelchair by '90. I kind of laughed at them. And then they put the body cast on me. I had that on for six months, and they

told me not to lift over five pounds. On the third day or something I was out in the boat jigging fish with the body cast on, sure. [laughs] So I mean if I had done what them doctors told me to do – lie down and do nothing, I'd be still laid down because if you lies down for six months, you knows your joints got to get stiff, you know, and you got to – have willpower.

Discussing stories

The pervasiveness of occupational identity was apparent throughout each of the narrative accounts of these fish harvesters who had been injured out of the industry. Work was central to their identities [21]. However, it was not just any work but rather work as fish harvesters. Their injuries led to a major biographical disruption (cf. [3]). Now that they could no longer work as fish harvesters, their whole identities were challenged. They felt out of place in their communities where the dominant occupation was fishing. Even some of their neighbors looked upon them with suspicion. The eagerness of the participants to tell their stories could be considered part of an ongoing attempt to redefine themselves. In particular, they resented the definition of themselves as malingerers. They were using the interviews as an opportunity to define themselves publicly as hard-working individuals who would much prefer to

return to their traditional employment than to remain on disability benefit.

The four narrative orientations identified in their accounts extend our understanding of the experience of disability among fish harvesters. These narrative accounts provide a description of the process through which fish harvesters attempt to manage the impact of the disability. The four orientations are similar to the three-fold narrative structure of regression, stability and progression identified by other researchers [?]. The destructive narrative was very much 'regressive'; the challenge and phenomenon narratives were 'stable' while the opportunity narrative was 'progressive'.

Robinson [19] found evidence of this three-fold structure in the narrative accounts of people with multiple sclerosis (MS). He invited a sample of people with MS to write about their illness. The majority of the narratives were classified as 'progressive' in that the patients described their disease as providing an opportunity for personal advancement. Others were classified as 'stable' and a minority as 'regressive'. This preference for a progressive orientation in these RA narratives reflects certain socio-cultural and personal processes. In western society a popular cultural narrative is that not only can illness be a positive experience but that also a person can exert control over their illness [1]. Adopting a progressive

narrative allows the patient to transcend the physical infirmity of MS. In the case of the fish harvesters it was difficult for them to identify anything positive in their disability. Since they remained in fishing communities they were constantly reminded of their former occupation. It was difficult for them to explore other occupational identities unless they left their small communities. It was only the older workers who had begun to explore alternative identities and to develop a more progressive narrative. The new identities of these individuals were rooted in their communities but outside of the fishing industry. They were now former fish harvesters.

We can also connect the four narrative orientations with broader cultural narratives such as those described by Crossley [4] in her study of HIV+ individuals. She identified three temporal orientations in the HIV+ accounts, each connected with a particular cultural narrative, viz. a 'living with a philosophy of the present' narrative orientation that was associated with a general cultural story of 'conversion/growth'; a 'living in the future' narrative orientation that was associated with a 'normalizing' cultural narrative; and a 'living in the empty present' narrative orientation that was associated with a cultural story of loss.

Those fish harvesters who developed a disability as destruction narrative can be described as living in the past or an 'empty present'. They

had still to disengage themselves from their lives as fish harvesters and felt unsure about what the future held for them. Their residential circumstances in fishing communities restricted their opportunity to explore alternative identities. Their cultural story was one of loss. Isolated in small fishing communities these disabled fish harvesters felt that the future held few prospects for them. Without the security of their fishing identity they felt adrift in their world.

This account was especially typical of the in-shore fish harvesters. They emphasized the deep-seated nature of this fish harvester identity, e.g. "It's in my blood and it's the heart and bottom of the soul" (Red). A study of New England fishermen [17] distinguished between in-shore and deep-sea fish harvesters. They found that in-shore fishermen were more satisfied with high level needs such as self-actualization and self-esteem whereas the deep-sea fishermen were more satisfied with basic level needs such as income. It is the loss of their ability to satisfy high-level identity needs that is most destructive for the in-shore fish harvesters.

Those fish harvesters whose narrative described disability as a challenge attempted in their everyday lives to work out ways to overcome the limitations associated with the disability. These fish harvesters could be described as living in the present. Their cultural story was a normalizing narrative. This involved them re-

defining themselves as partial fish harvesters. By doing so they held onto their fishing identity.

Those who recounted a disability as phenomenon narrative were distancing themselves from the impact of the injury. They were also living in the present but their present did not hold up the option of a return to the fishery but it was one of attempting to adjust to a new work identity. It also involved an organized approach in their dealings with government agencies such as the workers' compensation system. Their cultural story was one of struggle. They were still wounded fish harvesters and were tentatively exploring alternative identities.

The disability as opportunity narrative was somewhat more optimistic. For these fish harvesters an acceptance that there was no prospect of a return to the fishery led them to identify other often non-work related opportunities. Their life as a fish harvester was in the past. They could recount many exciting tales but these were consigned to the past. They were also living in the present but their cultural story was more one of conversion/growth. They were no longer fish harvesters – that was part of their earlier life. Instead they were exploring new opportunities in their communities.

Narrative orientations are not fixed but rather individuals can move from one to another. In the case of the injured fish harvester such movement

would depend upon a variety of factors including the severity of the injury, local opportunities, previous experiences, and social support. An important factor is the age at which the injury/disability occurs. If it occurs at an early age then the fish harvester may feel that his/her life is ruined whereas if it occurs at an older age than the fish harvester may be more able to accept it.

It is important to consider the temporal dimension of the narrative accounts [5,6]. In doing so it is possible to connect all four of the narrative structures suggested for our injured fish harvesters' accounts. In the initial stages the devastation narrative is most pronounced. At this stage the fish harvesters can be said to be living largely in the past. Then as the fish harvesters begin to grasp the character of the disability the narrative is more one of challenge. This is the stage of living in the present. Then they begin to take a more future orientation and to explore the opportunities posed by the disability. Of course this sequence is not linear. Rather the fish harvester can move between narratives depending upon circumstances. Thus while in general he may have an opportunity narrative on certain occasions he may revert to the devastation narrative when confronting particular challenges. The malleability of the reactions offers the prospect of intervention to improve the quality of life of these fish harvesters who are

unable to return to full-time work in the industry.

This research illustrates the close interweaving of narrative identity with community and cultural context. The fish harvesters defined themselves strongly with their work and with their community. Breaking this connection meant breaking their identity. Interventions to support disabled fish harvesters need to consider the strength of their attachment to the industry and the challenge in developing a new identity. The prospect of returning to work is slim for many of them (cf. [18]). However, their quality of life could be improved by service providers giving more attention to the particular meanings of work for them, the different narrative orientations and the social circumstances and opportunities. Providing the fish harvesters with a place to validate their identity as honest and hard working individuals would be an important part of the process of adjustment.

Although this study focused on the reactions of fish harvesters to injury and disability it would be expected that other groups of injured workers would have similar experiences. The particular character of fish harvesters is their close connection with their community and with their occupation. Following injury they may be no longer able to continue working in the fishing industry but they encounter daily reminders of their work. This prolongs

the period of adjustment and adds a special challenge to rehabilitation service providers.

PART III

CHAPTER 12

STUDYING SOCIAL NARRATIVES AND CHANGING SOCIAL REPRESENTATIONS

Introduction

Narrative theory is concerned with one of the defining characteristics of being human: the ability to create stories about our everyday lives. It is through these stories that we make sense of the world, convey this sense to others, and define ourselves. In this chapter we will consider the potential narrative theory has for increasing our understanding of the experience of health, illness and injury. It will also consider social representations that are those broad shared understandings of reality specific to a particular community or society. We will reflect on how narratives are on the one hand the motor force of social representations but how they are also anchored in underlying social representations. Finally, we will consider how to challenge unhealthy social representations through developing counter narratives.

Narrative theory

The past twenty years has seen a growing interest in narrative theory, initially as a component of literary theory but increasingly within the social sciences. The Russian literatist Vladimir Propp (1928/1968) in his detailed analysis of folktales argued

that they had a common underlying structure. Basically this structure consisted of seven fundamental spheres of action and thirty-one fixed elements. Subsequently the Canadian critic Northrope Frye (1956) argued after a very extended review of centuries of literature that there were four main narrative categories: comic, romantic, tragic and ironic. While debates regarding the adequacy of these and other forms of structuralist analysis continue within literary theory, within psychology and the social sciences there has grown the idea that narratives do not simply exist in books but are a much more pervasive feature of everyday social interaction and meaning-making.

Psychologists such as Ted Sarbin (1986) and Jerome Bruner (1986) were two of the earliest enthusiasts of this approach. While Sarbin argued that narrative is a superior root metaphor than the machine for developing a discipline of psychology, Bruner argued that there are basically two ways of knowing about the world – the scientific and the narrative. In everyday life, the narrative form is the more dominant way of knowing and as such should be the concern of psychologists who are interested in

how we construct everyday knowledge.

However, we not only make sense of our worlds through narrative but we also make sense of ourselves and indeed construct our identities through narrative. Dan McAdams (1993) and Mark Freeman (1993) among others have developed this argument. Their case is summarized in the famous quote from Jean Paul Sartre's (1964) novel *Nausea* in which the central character Roquentin pronounces:

[A] man is always a teller of tales, he 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 own life as if he were telling a story. (p. 39)

Although much of the research into narrative has been at the level of the personal or interpersonal, it is also possible to consider social or societal narratives (Murray, 2000). Thus, a society or community defines itself through the stories it tells itself about its history and experiences. It is these social stories that define a community and distinguish it from other communities. Further, these social stories can both divide and connect communities depending upon how previous contact between the communities is defined. For example, the narrative history of two communities may be one of exploitation and conflict such that it is difficult for them to share and live

together despite common interests and resources. As these societal narratives become more detached from their specific historical context, they can attain mythic status in a community. Sarbin (1997) has argued that it is these myths that "hold societies together, bind the past, present and future, and provide the outlines for constructing moral codes that define good and evil. Myths provide the foundational subtexts for sacred stories, the moral messages of which are given ontological status, that is, they are taken for granted beyond doubt" (p. 74).

Narratives of health and illness

Narrative theory can be used to explore the everyday experience of illness. This is apparent in a number of recent studies by health psychologists. For example, Mathieson and Stam (1995) have argued that it is through narrative that women begin to create a new identity after the experience of surgery for breast cancer. Through their detailed analysis of women's cancer narratives, these two researchers identified three major concerns: disrupted feelings of fit concerning bodily and other changes in the woman's life; renegotiating identity; and biographical work whereby the women attempt to negotiate with themselves and others a new coherent sense of identity.

In a subsequent study, Yaskowich and Stam (2003) extended

the idea of renegotiating identity by arguing that the process of biographical identity work is particularly pervasive in support groups for these women. Through detailed analysis of the conversation in a sample of these support groups the two researchers suggested that the groups provide a 'separate social space' within which the women could comfortably engage in the process of biographical work and the construction of new narrative identities.

Another example is the study of a sample of published accounts of the personal experience of breast cancer (Murray, 1997). In this study, I used Marilyn Chandler's (1990) idea that crisis narratives have three common literary problems: finding words for the inexpressible, obtaining narrative perspective and choosing a narrative form. Crises are often said to render one speechless – indeed it could be argued that a defining quality of the intensity of a crisis is the extent that it is 'beyond words'. This silence is compounded by the broader social representation of the cancer as insidious (see Sontag, 1978) and the extent to which the victim can be identified as morally culpable. Despite developments in medical treatment there remains a silence about breast cancer (see Blaxter, 1983). In their accounts, the women often wrote about the challenge of talking about the disease publicly. In a much broader setting, this challenge has

been discussed extensively in historical (for example, Langer, 1991) and more recently psychological (for example, Kraft, 2002) research on developing oral and written narrative accounts of the Holocaust atrocities.

Secondly, the formation of the narrative account also enables the narrator to obtain a certain amount of narrative distance or perspective. By creating their narrative account the women were able to obtain this narrative distance and then, as it were, move on with their lives. In his work on the difficulty of developing personal narrative accounts of the Holocaust, Kraft argues that in order to learn about a new event it is necessary to assimilate it into prior knowledge (cf. the concept of anchoring below). In the case of the Holocaust the horror is so outside the normal range of imagination that the narrator finds it difficult to assimilate it into prior knowledge and so in attempting to recount the details the narrator will sometimes slip back into re-experiencing the horrors.

Thirdly, there is the issue of narrative form. In reviewing the cancer stories, I argued that the most popular form was that of the battle against the evil enemy. Admittedly, many of the women wanted to play down their role as the hero but that rather they won the battle with the help of science or religion (see also Murray, 2003).

In a third example, Crossley (1999a,b) used narrative theory to

explore how individuals with AIDS redefine themselves after they are diagnosed with the disease. She was particularly concerned with exploring the source of these stories not within the individual but within the broader culture. For example, she argued that the HIV positive individuals make use one of three “dominant cultural ‘stories’” (Crossley, 1999a), namely the normalizing story, the conversion/growth story, and the loss story. In ‘choosing’ or engaging with one of these cultural stories the individuals are led to interpret and to adapt to their illness in a different fashion. This threefold classification of narratives is very similar to the stable, progressive and regressive structure suggested by Gergen & Gergen (1986) (see also Murray, 2002).

In telling the stories, it is important to realise that there is always an audience, real or imagined. A challenge faced by crisis or trauma narrators is the perceived reluctance of the audience to listen or the belief that the audience will not understand. In our analysis of the women’s breast cancer narratives many of them reported that their family and friends did not want to listen – they wanted to get back to their everyday lives. This agrees with Yaskowich and Stam’s argument that women with breast cancer attend support groups because there they will find someone who will listen and whom they believe will understand. Similarly, Langer argued that many of the Holocaust survivors

felt that it was useless even attempting to recount a narrative since no one could understand the horrors except a fellow survivor. As one survivor recounted:

Because to understand us, somebody has to go through with it. Because nobody, but nobody fully understands us. (p. xiv)

Researchers can deliberately attempt to break down this wall of silence and to engage with the audience. An example is the work of Ross Gray and his colleagues who have explored how women react to the diagnosis of breast cancer and men to the diagnosis of prostate cancer. In these studies, the different narrative accounts of the participants were used to develop a series of plays that were then returned both to the participants and to a wider audience. Gray has considered a range of broader issues concerning the role of the researcher in the research process and how the researcher can begin to challenge widespread but disempowering narratives. The full details of the work are provided in Gray (2003) and Gray and Sinding (2002).

In reflecting on the process of writing plays about the experience of cancer, Gray and Sinding (2002) explored the tension between wanting their plays to publicly ‘represent’ the experience of having cancer and at the same time evoke some feeling and empathy in the audience. It is not possible to simply summarize the

transcripts of the narrative interviews. Rather, the playwright selects certain issues and organizes them into a certain form to convey a certain story and to engage with the audience. Denzin (1997) views play writing as being based upon “an evocative epistemology that performs rather than represents the world” (p. 115). The play does not only connect with the audience but can also engage with the broader process of what Gray and Sinding have described as ‘cultural critique’. By this, they mean that the play begins to expose the particular demands placed upon the cancer patient by both their peers and by the medical system. The audience members can thus not only begin to sympathetically experience the actual disease but also become aware of these broader social demands. As such, the play becomes an opportunity to expose and to critique broader social representations about the nature of health, illness and healthcare.

Social representation theory

In contrast to the individualistic information processing models that dominate much social cognition research in health psychology, social representation theory is based upon a socially dynamic view of human thought and action. It is concerned with understanding social knowledge or the ways of understanding the world developed and exchanged within a community or a collective. This particular theoretical approach

was developed by the French social psychologist Serge Moscovici. It was derived from Durkheim’s notion of collective representation that describes the over-arching assumptions of any particular society. However, whereas collective representations are static, social representations are dynamic and are derived from the ongoing exchange of social knowledge in any particular community (see Markova, 1996). In an often-repeated definition Moscovici described social representations as:

a set of concepts, statements and explanations originating in daily life in the course of inter-individual communications. They are the equivalent in our society of the myths and belief systems in traditional societies; they may even be said [to be] the contemporary version of common sense (Moscovici, 1981 p.181).

Two processes are considered to be involved in the dynamic workings of social representations. On the one hand is the process of *anchoring* through which we interpret new phenomena by connecting them with more established phenomena. An example taken from some of the original work of Moscovici is the anchoring of new psychoanalytic concepts in more established religious knowledge. Thus, the unconscious was anchored in the familiar Catholic concept of conscience. The other process is that of *objectification* by

which we give meaning to an abstract concept by giving it concrete substance. Taking another example from psychoanalysis, the abstract concepts of id, ego and super-ego are objectified and assumed to be compartment-like entities in the individual mind. Again they could also be connected to religious entities such that the evil of the id can be objectified in the devil while good or the super-ego can be objectified in the angel.

Social representations can be said to have two roles. On the one hand, they *conventionalize* new objects or events. As such, they define and protect social groups from threat. The emergence of new challenges initiates the development of new social representations that attempt make sense of this potential threat. Moscovici (1984) argues: "the act of representation is a means of transferring what disturbs us, what threatens our universe, from the outside to the inside, from far off to near by" (p. 26).

The second role of social representations is that they are *prescriptive*. They not only evolve in particular societies, but they also shape the workings of those communities. As Moscovici (1984) stated: "they impose themselves upon us with an irresistible force" (p. 23). It is these social representations that guide our everyday social exchanges. In this sense, they can be said to have a function in that they enable the smooth working of a society.

Social representation theory is itself a dynamic framework that is enriched by connection with other theories. These connections are increasingly being explored. For example, Joffe (1996) has explored the connection with psychoanalytic theory and Colucci (1995) has explored its connection with Marxist and more explicitly Gramscian theory. Later in this chapter we will consider its connection with narrative theory.

There has been a steady growth of empirical research using social representation theory as a conceptual framework. This research program has adopted a wide range of methodologies ranging from the experimental (for example, Doise, Clemence and Lorenzi-Cioldi, 1993) through to the ethnographic (for example, Jodelet, 1991). The focus is not on the particulars of the method but rather on its ability to unpack the various dimensions of the specific social representation (Murray and Flick, 2002).

Social representations of health and illness

The classic study of social representations of health and illness was that conducted by Claudine Herzlich (1973) in the 1960s. She carried out detailed interviews with a sample of French middle class and rural workers. She concluded that health is commonly conceptualized both as an attribute of individuals and as a result of the degree of balance

between self and society. The individual is considered a reservoir of health whereas as society is considered the source of illness. It is through maintaining this balance or harmony between self and society that health is maintained. When balance is threatened, either through wear and tear of the individual body or negative changes in the world, illness results. In addition, Herzlich conceptualized illness in terms of an occupation, as a liberator or as a destructor. Previously (Murray, 2002), I have noted how this three-fold definition of illness has been reflected in several studies of lay understandings of illness (cf. Crossley, 1999a).

A series of recent empirical studies have extended the original work by Herzlich. Flick (2000) compared the social representations of health among East and West German clerks and nurses. While he found support for Herzlich's basic model he found more evidence that health was defined in terms of lifestyle. In addition, Flick compared the social representations of health among Portuguese and German women. Among Portuguese women he found that a central component of their definitions was a 'lack of awareness' of health. By this, he meant that these women did not seem particularly concerned about their health. He attributed this fatalistic attitude to the repressive social regime that had ruled in Portugal for many years. Conversely, the German women

emphasized a feeling of being 'forced to health'. By this, he meant that the women felt pressurized to be healthy and to look after their health. According to Flick, this reflects a popular German media message of being responsible for your own health.

This argument was extended by some recent work we have been conducting on social representations of health and illness held by baby-boomers in Canada (Murray, Pullman & Rodgers, 2003). In this study, we conducted individual interviews and group discussions with a large cross-section of Canadians. In an analysis of those resident in Atlantic Canada, we found that although there was frequent reference to lifestyle in discussion of health this was particularly apparent among more middle-class and professional participants, the working class participants were more sceptical of the importance of lifestyle. This illustrates how different constituencies in a larger society can engage with dominant representations of health in different ways depending upon their life circumstances— one in an accommodative manner and the other in a resistant manner.

A criticism sometimes levelled at social representation research is that it is concerned with describing social phenomenon and does not contribute theoretically to offering a solution to improving health. While this may have been the case in earlier formulations, increasingly researchers

have begun to explore how social representation theory can also be linked to measures to improve health status.

For example, Campbell (1998) in her study of social representations of gender in the context of AIDS prevention work in South Africa used SR theory as a framework. She was particularly concerned to articulate an alternative to the traditional information based health education programs. Her research involved detailed qualitative interviews with a sample of sex workers who lived in a mining community. She concluded that 'the central representation informing people's life stories was that of themselves as helpless victims of poverty and male oppression' (p. 689). This denial of agency on the part of the women was considered a major obstacle to the development of assertiveness skills for safer sexual behaviour. Campbell concluded that peer education methods provide an opportunity to challenge this lack of agency on the part of the women and to help them build the confidence necessary to adopt safer sex practices.

Joffe (1996) in another study of social representations of AIDS in South Africa and England also addressed this issue. She contrasted the dominant knowledge-attitude model of health promotion with that of social representation theory. The former separates thought and action and assumes a causal relationship between them. This approach tends to

focus on 'improving' individual thought and ignoring other social contextual processes. While the knowledge-attitude model focuses on the individual actor, the social representation approach is concerned with understanding the development and operation of broad social assumptions about reality. These social representations can be resistant to change since they have the function of maintaining a certain stability in a society. For example, Joffe notes that the social representation of AIDS that locates it in the sexual preferences of a minority group provides the dominant group with a sense of immunity. It is for this reason that Joffe concludes that issues of identity protection need to be central to AIDS campaigns.

Markova and Wilkie (1997) in their analysis of representations of AIDS illustrated the role of minority groups and the media in challenging and changing dominant social representations. They contrasted public reaction to syphilis in the 19th century with that to AIDS in the late 20th century. There were certain similarities but also important differences. In both cases, the public response to the diseases was anchored in death, stigma, 'improper sexual behaviour' and 'just' punishment'. However, the content of these responses differed sharply due to the changing moral climate and the role of those afflicted. The 19th century was an era of conservative sexual morality that clashed with the diverse

background of people infected with venereal disease. The official response was that in order to maintain the traditional family it was necessary to abstain from casual sex or at best take precautions. In the late 20th century the disease initially largely afflicted a minority group – homosexuals. This group was influential in promoting a broader acceptance of different sexual practices such that the public response to the growth of AIDS was less to blame the gay community for the spread of the disease but rather to suggest that it was those, both straight and gay, who did not take precautions. This message was widely promoted in the media. Markova and Wilkie concluded:

The voices of the homosexual community and the press in the present public effort to cope with AIDS clearly show that social representations are formed, maintained and changed through an interaction of the conservative point of view of society with new ideas of individuals and minorities, disturbing those these may be. (p. 406)

This conclusion raises another important point developed by Moscovici (1976), which is the role of the minority in changing society. While the minority has often been viewed as ineffectual, Moscovici has argued that it can be very important in introducing social change through challenging dominant ideas. The

impact of the minority is particularly influential when its argument is consistent, when it is coherent and when it is presented in a forceful manner. These features are important in attempts to challenge dominant social representations.

Linking narratives and social representations of health and illness

Since both narrative and social representation theory are concerned with popular understandings of the world, it is not surprising that several researchers have recently begun to explore further their interconnections. Laszlo (1997) has argued that much previous empirical researchers have imposed a categorical structure on particular social representations and ignored their underlying narrative character. He referred in particular to the work of Herzlich (1973). Recently, I extending this argument by looking in more detail at the empirical work reported by Herzlich (Murray, 2002). It was apparent that material used to justify the three dimensional model of illness she developed was composed of mini-narratives. Indeed, the very structure of the social representations of illness suggested by Herzlich was in many ways similar to classic narrative structures. Thus, the illness as liberation was comparable to the progressive narrative; illness as destruction was similar to the regressive social narrative while illness as an occupation was similar to the stable social narrative (Gergen and

Gergen, 1986). These narrative structures can be said to provide a temporal or historical dimension to social representations. Consideration of time has often been ignored in social representation research. Flick (1995) introduced the concept *retrospective anchoring* to connect interpretations of contemporary phenomena with previous events. Although as a society we may eagerly encounter new phenomena, these are often clothed in the language of past events that can act as a disincentive to progress. As Karl Marx (1852/1968) argued:

The tradition of all the dead generations weighs like a nightmare on the brain of the living. And just when they seem engaged in revolutionizing themselves and things, in creating something that has never yet existed, precisely in such periods of revolutionary crisis they anxiously conjure up the spirits of the past to their service and borrow from them names, battle cries and costumes in order to present the new scene of world history in this time-honoured disguise and this borrowed language. (p. 96)

For example, during periods of communal conflict the costumes worn by different communities and the frequent references to ancient rivalries by their leaders illustrate how we can continue to live in the narratives of the past. Interpretations of contemporary

events are anchored in stories of past grievances that can continue to provide emotional currency.

It is through the exchange of narratives that communities develop and maintain social representations. Examples from anthropological work have previously been used to illustrate the role of stories in the development of social representations of particular diseases (see Murray, 2000). For example, in Farmer's (1994) study of the development of what he described as cultural representations of AIDS in Haiti he noted how over time particular stories about the disease began to circulate and carried with them certain ideas about its contagion. However, these narratives did not contain a novel explanation for AIDS but rather the explanation was clearly connected to an earlier model of tuberculosis. Farmer refers to the previous comment by Byron Good (1977) on the evolution of popular ideas about illness in Iran. Good noted:

As new medical terms become known in a society, they find their way into existing semantic networks. Thus while new explanatory models may be introduced, it is clear that changes in medical rationality seldom follow quickly. (p. 27)

People exchange narratives in their everyday social interaction. While these narratives may be concerned about immediate events their assumptions draw upon and

confirm certain social representations. For example, in telling a story about an exchange between a man and a woman we are drawing upon broader social representations about gender relationships (see Campbell, 1998). Further, the particulars of a specific story help to both anchor and to objectify an event that can seem abstract. We can explore this further by considering the underlying assumptions of a series of stories about injury in the fishing industry.

Fish harvesters' tales

The fishery is one of the most dangerous of occupations in the world. Mortality statistics from many different countries confirm that people who work in this industry are at risk from a wide range of injuries. Despite this finding, it has attracted relatively little social and behavioural research. Although, increasingly, fishing is conducted in an industrial fashion with large ships, the vast majority of fishing throughout the world is still conducted in small boats crewed by one or a limited number of fishers. Traditionally these fishers have learned the skills of their trade from their fathers or uncles.

Newfoundland has historically had a major fishing industry. It was largely settled in the 18th and 19th centuries by fishermen from Ireland and England. In Irish, the province is named *Talamh an Eisc* or Land of the fish. For hundreds of years the most important source of income for the

nation and then province was the fishery. The structure of the fisheries has changed radically over the past decade but it still remains an important component of the economy.

We conducted a study of the experience of fishing in the inshore among a selected number of fishers who resided in different communities around the island of Newfoundland (Murray and Dolomount, 1994). In that study, we carried out detailed interviews with the fishers and followed this up with an extensive survey. The interviews were tape-recorded, transcribed and then reviewed. Although narrative was not the formal theoretical framework for the interviews, it rapidly became apparent in reviewing the transcripts that the fishers used the interviews to recount lots of tales about the experience of fishing. This was facilitated by the adoption of a broad life-course perspective in the structure of the interview in which the interviewer asked the fishers to recall particulars of how they entered the fishery, their experiences of working in it, the hazards they encountered and the prospects for the future of the industry.

Each of the fishermen recalled many examples of injuries they or their colleagues had incurred ranging from minor cuts and bruises to amputations and drownings. The narrative accounts they provided had a common structure of the individual fisher doing battle with the cruel sea.

The narratives connect with the 'frontier myth' that Sarbin (1997) argues is central to understanding contemporary American culture. In that myth, according to Sarbin:

The plot structure is built around a superhero and the image of a harmonious community threatened by sinister forces. Institutions that might cope with evil forces are weak, corrupt or absent. An altruistic hero appears, and through the exercise of violence eliminates the evil-doers, thus re-establishing harmony in the community (p. 75)

While these narrative accounts can be analysed as things in themselves or connected to mythic stories we can also identify the underlying dynamics of the stories through careful consideration of their structure by meshing them within the concept of social representations. Reading across these fishers' stories we can infer two broad social representations, views shared to a varying extent by the fish harvesters but providing the framework for a common social world. The first concerns the nature of masculinity. There were several aspects to this including hard work, lack of constraints, and the excitement it provides. For example, Joe a young fisherman summed up his view of fishing:

Oh, I loves fishing. I wouldn't go at nothing else. You're your

own boss...you can come and go whenever you feel like it. If you don't feel like going out you got nobody to answer to, clear of your family, that's all. It don't even come to mind [the risks]. It's part of your job, I don't even think about it.

The fishermen continued to tell lots of personal anecdotes about going to sea and doing battle with the elements. The advent of industrial fishing threatened this traditional role:

I mean, that's the way it was. They are a hearty breed of people, you know. Nobody wants to see that changing. The fishermen are proud that they can work and make a living from the sea, right. Once you gets aboard those bigger factory boats and bigger trawlers, you're only a worker then.

It was through these stories that the fishers told tales of adventure and hard work.

The second social representation concerned the relationship of the individual with what was perceived as an unpredictable world. While you could try to take precautions, there were many things in life that were in effect pre-ordained. As Cecil, an older fisher stated:

Dangerous, yes, but again, there's a difference. There's two kinds of dangers. There's dangers that's carelessness, and there's dangers that you just

can't avoid. Sometimes you got to be in danger ... in the fishery, a real lot of danger that you just can't avoid.

In providing their accounts of their everyday working life, the fishers are constructing what could be described as a morality tale. They lived in a capricious world where their working life was threatened by the wiles of the sea and increasingly by a neglectful government. They were responsible people but they had to survive and feed their families. Thus they went to sea as their fathers had done for generations. They took precautions but despite that the sea held many dangers that it was impossible to avoid.

Challenging social representations and promoting health

Social representations are not only dynamic in that they evolve and change in everyday social interaction but they are also proscriptive in that they establish guidelines for everyday behaviour. Thus, attempts to improve the health of a community must consider the character of particular social representations. An example of this is the work of Campbell (1997) in which she considered the role social representations of masculinity play in restricting the impact of sex education on South African mine workers. For these men, the equating of masculinity with risk-taking was necessary for their continued work in the dangerous conditions of mining. Campbell

described these social representations as adaptive in the sense that they allowed men to continue to work in extremely unsafe conditions.

An important part of the process of challenge is the role of the minority that was discussed earlier. An example of this is the so-called 'coming out' story that has been recently associated with public declarations of sexual preferences. Down through history an important component of how a minority group has challenged established wisdom and begun to develop support for a new perspective was through the process of 'giving witness'. By doing this, the committed articulated their alternative perspectives, often by publicly declaring their stories of conversion. St. Augustine provides an archetypal conversion story. In the health arena, the role of key figures publicly declaring their rejection of established wisdom plays an important role in changing social representations.

Another potential strategy for challenging social representations is to involve the community in developing particular new narratives. An example of the application of such an approach to improving health and safety is provided by some recent work on farm safety developed by Tim Struttman and his colleagues in Kentucky (for example, Struttman, Brandt, Morgan, Piercey and Cole, 2001). Like the fisheries, farming is a very dangerous occupation. It is also

male-dominated and despite the growth of large farms, still involves a considerable number of farmers working alone. Attempts to convince these small farmers to adopt various safe practices have not always met with success. These education efforts have often adopted a didactic information based approach.

In this study, small farmers and their wives were introduced to a series of safety messages through drama and storytelling. The strategy used to develop the plays was very similar to that used by Ross Gray and his colleagues and described earlier. Stories of injury and farm life were collected from the farmers themselves and then welded into short plays that both conveyed the risk of certain actions but also provided an opportunity for the farmers to collectively consider alternative safer practices. In doing so, the farmers were provided with an opportunity to challenge the more standard social representation of the risky male and of the fatalistic attitude to life that is widespread in this community. Initial evaluation of this form of intervention is promising. Currently, plans are underway to connect both of these approaches in the development of a safety program for fish harvesters.

In developing these new local stories we can also begin the task of challenging the broader myths that shape the structure of our societies and help to perpetuate social injustice. One supposed characteristic of late

modernity is the collapse of metanarratives - those grand stories that have served to legitimize the inequities in modern society. In their collection entitled *Counter Narratives*, Henry Giroux and his colleagues have argued that there is an urgent need to intervene to develop counter narratives that can enhance the strength of the oppressed and challenge the power of the establishment (Giroux, Lankshear, McLaren and Peters, 1996). These counter narratives, according to Peters and Lankshear (1996) "serve the strategic political function of splintering and disturbing grand stories which gain their legitimacy from foundational myths concerning the origins and development of an unbroken history of the West based on the evolutionary ideal of progress" (p. 2). This means confronting the fatalism that pervades much contemporary political engagement and exposing the hidden assumptions within oppressive social representations. It also means beginning to develop an alternative social narrative that offers the prospect of both greater health and social justice. The details of such a narrative are developed elsewhere in this book (see chapters 4, 9 and 11).

Conclusion

Developing a critical health psychology requires connecting ideas with practice to enhance health. The linkage of ideas from narrative and

social representation theory provides a starting point for such an endeavour but it needs to be linked to a perspective of social change or transformation. This perspective can be both at the local and at the broader level. More details of how to work with communities to promote health and social change are considered in subsequent chapters.

CHAPTER 13

FROM NARRATIVES OF RESISTANCE TO SOCIAL REPRESENTATIONS OF OPPRESSION AND VICE VERSA

Much previous work on narrative has concentrated on the character and structure of the individual narrative. It is important at the outset to remember that narrative accounts do not spring out of thin air but are social constructions. We are born into a storied world and draw upon the cultural stock of stories. In addition, we tell stories to other people, real or imagined. This story telling has a reflective consequence in the development of narrative identity. In the same way as Vygotsky (1962) talked about the development of thought through language we can talk about the development of identity through storytelling.

However, stories are not just told by and about ourselves or about individual people but by and about collectives. In addition, they engage with and participate in the construction of broader social representations. The aim of this contribution is to reflect upon the interweaving of narratives and social representations. In doing so I draw upon some work I previously published on the historical connections between narrative and social representations theory (Murray, 2002). I also draw upon some empirical

work I have conducted over the past five or more years – particularly a study of fish harvesters, a study of older residents of a disadvantaged community, and a study of mental health service users. These studies have many similarities since they are all concerned with the narrative accounts of the everyday experiences of marginalised groups and also they were concerned with developing social interventions designed to enhance quality of life and challenge oppressive social representations and relations.

Much of the literature on narrative focuses on the character of personal biographical accounts. Like many other, I have drawn upon the work of the French philosopher Paul Ricoeur. In his extensive writings he was concerned in particular with the temporal character of human experience and the role of narrative in making sense of that experience. As he has argued:

‘one presupposition commands all the others, that what is ultimately at stake in the case of the structural identity of the narrative function as well as in that of the truth claim of every narrative work, is the temporal character of human

experience. The world unfolded by every narrative work is always a narrative world. Or, as will be repeated in the course of this study, time becomes human time to the extent that it is organised after the manner of a narrative; narrative, in turn, is meaningful to the extent that it portrays the features of temporal experience. (Ricoeur, 1984).

Elsewhere he describes narrative as the 'emplotment' of human experience, providing a sense of order and coherence. These personal narrative accounts not only provide order to our experience but provide us with a sense of personal history and identity.

While this work on personal narrative and identity-making is important it is also important to locate the processes within both the immediate context within which the narratives are told and the broader socio-cultural context. Ann Phoenix (2008) has commented on how in interpreting the character of particular narratives we need to be aware of both the local and broader social context. In the research context we usually collect stories in interviews but also in group settings. In addition, although these stories may be about individual experiences they can also be about our group or community. In the narrative account the story teller can position herself as a representative of that group or community.

In addition, in our story telling we connect with the social representations of our own group but also the perceived social representations of other groups (see Howarth, 2002). Elsewhere I have deliberately explored the connections between narrative theory and social representation theory drawing upon the work of Janos Laszlo (2008). I will recap these connections briefly here. Social representation theory is an approach to our understanding of social reality that was developed by Serge Moscovici. In a much used quotation he defined social representations as

'a set of concepts, statements and explanations originating in daily life in the course of inter-individual communications. They are the equivalent in our society of the myths and belief systems in traditional societies; they might even be said to be the contemporary version of common sense.' (Moscovici, 1981)

But where do these social representations come from. Moscovici argues that they are created and recreated in everyday social interaction. More specifically, he describes them as

'the outcome of an unceasing babble and a permanent dialogue between individuals, a dialogue that is both internal and external,

during which individual representations are echoed or complemented.

Representations adapt to the flow of interactions between groups'. (Moscovici, 1984)

Even further, he argued that they are created in

'those microcosms, the cafés, and other places where people meet to talk.' (Moscovici, 1984)

We need to look further at the character of those everyday conversations. We know from our personal experience that these often take the form of stories such that when we talk to others we are telling stories about our own and others' experiences. Nowadays, this can occur not only during everyday physical interactions such as in the cafés but also at a distance through the internet. In doing so we not only contribute to social representations but we draw upon them as well such that it can be said that we engage with them in a dynamic way. It is this sharing of stories that is a defining characteristic of a community. We also distinguish our community from another by the social representations we have of the other and the perceived social representations we believe they hold of us

We not only contribute to the content of social representations but also to their structure. Lazslo (2008) has noted that previous research on social representations has considered

their categorical content and ignored their narrative structure. In the same way as Elliott Mishler (1986) talked about narratives being ignored by interviewers, social representation researchers have tended to ignore the role of narrative in shaping the very structure of these representations.

If we look at several studies of social representations of different phenomena we can see the connections with narrative structure. For example, we can consider narrative as having a basic three-fold structure of beginning, middle and end. In addition, Gergen and Gergen (1986) and others (e.g. Frye,) have suggested we can look at the dynamic of such a structure as being regressive, static or progressive. If we now look at studies of social representations of different phenomena we can see how a similar narrative structure pervades them. For example, Herzlich (1974) in her classic study of social representations of health and illness described illness being represented as destruction, occupation or liberation. Similarly, Greenspan (1998) in his description of representations of the holocaust talks about the victim, suffering and the survivor while in my own study of social representations of cancer it was apparent that people talked about it in terms of death, suffering, or re-birth (Murray & McMillan, 1988).

In the remainder of this chapter I want to explore somewhat more the connections between narratives and

social representations. I will do this through three empirical projects. These have been chosen because they attempted to go beyond looking at connections to explore the challenges of social and personal transformation.

Fish harvesters

The first is a study of the lives of fish harvesters. This was a study, or series of studies (Murray & Tilley, 2006; Murray, 2007), that I conducted over several years when I was resident in the province of Newfoundland, Canada. There the fishery has a long history and has been traditionally organised from small, isolated communities. In those communities the tradition was for the men to leave school at an early age to go fishing in small boats while the women worked in the fish plants. This was largely unskilled work for which the men, and more recently women, received minimal training. It is an industry which has a long record of disasters ranging from drownings to substantial injuries. More recently, the government has attempted to exert greater control over the fisheries including the introduction of safety regulations and training. These have been met with varying degrees of success.

In the studies we talked with fish harvesters about their lives. The narrative accounts confirmed that the men had worked in the fishery from a young age and had had regular encounters with accidents and injuries.

Despite this and the low income they were extremely enthusiastic about their work and had great pride in it. They talked about the independence of being a fish harvester

I've been at it all my life ... I loves fishing. I wouldn't go at nothing else. You're your own boss ... you can come and go whenever you feel like it. If you don't feel like going out you got nobody to answer to, clear of your family, that's all.

They are a hearty breed of people ... nobody wants to see that changing. The fishermen are proud that they can work and make a living from the sea. Once you get aboard those bigger factory boats and bigger trawlers, you're only a worker then.

and the excitement.

I loves it...The excitement I finds, when you are hauling the trap you can see the fish going, right.....same as when you're taking gear back, you see the fish coming on the gear. Going and just getting the fish. It's something ... whatever job you likes....a carpenter likes seeing a house go up, well, I likes to see fish coming in. Same thing I suppose. It is a challenge.

They also talked about the nature of fishing requiring the fish harvester to take risks – admittedly these were calculated risks.

In the fishery people are going to take risks, while the fishery is there, bigger risks than the other people, some people are more successful at it than others, and some people are not taking as big of a risk as long as they makes a go of it, you know, that's the nature of people, the way I sees it. If you gets into a fishing boat, anywhere in Newfoundland suppose, but up our way you're taking a risk everyday you goes out.

Together the image they presented was that of the hardworking and courageous individual.

Conversely, when they spoke about people from outside their small communities it was often with caution or even suspicion. It was felt that they knew little about their lives. The perceived outside social representation of fish harvesters was that they were basically lazy and ignorant and took advantage of the system.

A lot of people don't know about the fishery ... They're very ignorant of the fact ... they [think we] don't do anything in the winter time, only jump on their skidoos or on an ATV.

I'm after getting that said at me where I have to turn around and not letting them know that you was angry and giving them a good sharp answer – we owns our home but we worked real hard for that.

People don't understand about fishermen

So, we had this personal and community narrative of industry and resilience. In the interview setting the individual fish harvester was presenting himself as a representative of other fish harvesters often referring to 'we' as well as 'I'. He was also drawing upon and affirming the archetypal image of the male figure who was independent and could take risks.

Conversely, the perceived outsider social representation of the fish harvester was of indolence and ignorance. The fish harvester was keen to reject this image but was frustrated and angry at its common currency. Such perceptions led them to be sceptical of outsiders and also to treat with suspicion attempts by outside authority to regulate their activities.

To be honest with you, I've got to be straight forward, I don't believe in regulations ... because what I believe in is education. That, I think, is more important than regulations, because the fishermen are regulated to death.

We got intelligent fishermen out there, very intelligent.

In a subsequent study of injured fish harvesters who were claiming injury compensation this anger towards authority was even more pronounced.

The follow-up study was designed to find ways of improving safety in the fishery building upon an awareness of these narrative accounts of industry and perceived social representations of indolence. We attempted to do this with a series of community arts projects which deliberately worked with local residents of these communities to engage other residents in increasing debate and discussion about the nature of accidents and what could be done to reduce their frequency and to create a safer fishery. In doing so we developed songs, plays and other arts based activities. I will describe a few of these.

In one community we worked with a local singer/song-writer to compose songs about safety in the fishery. We shared with the song-writer some of the interviews we had conducted with fish harvesters and discussed possible issues to be introduced in the songs – building upon the narrative of pride and strength and introducing the need to take precautions. When subsequently performed, the song was very positively received by fish harvesters and was played widely.

In another community we worked with local residents to create and produce a play. After discussion of the aims of the project a local teacher volunteered to write a play which included details of local fishing tragedies and introduced the issue of safety. This play was performed by local residents who clearly identified

with the roles. When performed to local audiences it received an enthusiastic reception.

Together these and other activities were designed to build upon both the fish harvesters and other community residents narrative identity of strength and fortitude and to challenge the perceived negative social representation. It was also designed to challenge to fatalistic acceptance of injuries and to introduce the idea that accidents are not inevitable.

Older people

The second study is concerned with the lives of older people who live in disadvantaged urban areas (Murray et al, 2008). Previous research has confirmed that these people experience a wide variety of disadvantages including social isolation and demoralisation. Individual conversations and group discussions with some older residents of one inner city area clarified the character of this social isolation. They were keen to talk not just about themselves but about the whole community in which they were resident – often for 30 or 40 years. These historical narratives portrayed the community as being initially a place where people gathered together, supported each other and shared in their joys and sorrows. It was also a place in which work and religion played an important part in their identity. Now it was felt that there

was less support from within the community but also that the government and other institutions had forgotten them. Their image of the ideal community was one drawn from their youth but also perhaps reflected the idealised community often presented on television which was their primary source of entertainment.

This narrative of decline connected with the perceived negative social representation of their community held by others. Other city dwellers were thought to consider them of little consequence and the city council generally ignored them.

They say we are deprived.

They never come around here

This was reflected in their limited contact with city officials and councillors. The traditional role of the clergy had largely disappeared. Connecting this community story of decline with the perceived social representation of neglect helps to understand some of the older residents' feelings of despair and fatalism (e.g., 'People round here don't really care any more.') but also of frustration at wasted talents.

Our project was designed to challenge this perceived social representation of worthlessness by identifying and building upon the talents of local people. We have done this again through a series of arts projects. Initially we have worked with older residents to develop personal arts projects. The response to

this has been very positive. *Seems to be getting people together*

Very pleased with everything that's happening for the community

This social experiment is a success ... We're trying to rebuild our community. That's not going to happen but we are trying...'

Really feel I belong to something and this is time for me – as a carer this is so important

There was an awareness that they were not only demonstrating that they were able to do things, but also in the process they were developing social connections and planning new activities. Admittedly, there was a certain hesitancy about future developments.

Mental health service users

The third project was concerned with the experiences of mental health service users (Buchanan & Murray, 2009). It is well established that people who have had mental health problems encounter a range of challenges in their everyday lives. In conversation with a number of such people they confirmed these challenges in stories of exclusion and marginalisation.

I can say that I have definitely had problems with friends – at the beginning they probably find symptoms of depression, what were symptoms of depression, were mistaken for sort of like surliness

and just generally ... quite negative. Housing as well, I was going for a flat once and the landlord ... insisted that it was only depression that I had – if it was anything more serious he said he wouldn't have let me have the place.

You lose friends, you lose contact with society and before you know it you are in a sort of socially isolated situation and sometimes you wonder how you end up in that position.

In doing so they were drawing upon a cultural narrative of human rights – the right to be treated as an equal citizen. When they were asked about other people they described the perceived social representations of mental illness held by others as being filled with negative stereotypes and sensationalist ideas.

I think it's something society has a big problem with accepting people as individuals regardless of race, colour or religion when they are ill – physical or mental. As a society we find it very hard to see people as individuals we like to label them and fit them into the very stereotypical roles we have ... If someone has schizophrenia we assume they are violent

All that is ever reported is those that do [commit crimes] ... because that's all that's in the media – the

link is made that everybody must be like this. And people have these preconceived ideas which, because they come across in their personal lives ... the media is their only source of information unless they know someone whose been affected.

You have all these sensationalised ideas in the media

Connecting these local narratives of rejection and a broader human rights narrative with social representations of 'madness' equated on the one hand with acceptance and fatalism

I'm not a depressive person and I don't suffer from depression but when you have a label as that put on you what you do in life do you fight that label or do you get on with your life? And it's very difficult – it's a double whammy, a vicious circle, and I think it's a can of worms with all these labels. For myself personally I've given up doing that a long time ago

and on the other with frustration and anger on the other.

I'm a great believer now in ... let's top talking the talk and let's really walk the walk in terms of research ... it isn't enough that we've done a lot of research and evaluation ... but it seems to me not enough ... we are human beings, we're not models of behaviour ... I feel very negative and ashamed that there's

that much research being done about mental health

When are the shackles of mental health going to be broken once and for all, when are we going to start seeing people with mental health issues as real people not with the labels and anger

The collaborative video project we developed was designed to challenge the perceived negative public and media representations and through action develop a new narrative of agency and resistance. The volunteers in this project were keen to participate. At the conclusion they expressed satisfaction at what they had achieved but this was coupled with a certain acceptance at the small contribution they had made to broader change.

I find that one of the great problems of mental illness is that when you find yourself well, there are a great many barriers there to preclude you from leading a so-called 'normal' life. Being included in such a project, therefore, can help rebuild some confidence or motivation

I believe the project has had a positive impact on me personally

Reflections

In these three projects I was concerned with connecting personal and community narratives with perceived

social representations. Thus their narratives were often of frustrated ability and the perceived representations were often of negativity. The projects were attempts to engage in a process of challenge to those perceived social representations and to develop a new narrative of action and change. They demonstrated the capacity of the arts to challenge the perceived negative social representation and through action begin to develop a new narrative identity that confirmed strengths and integrity. As such it shows potential but also opens up some new dilemmas both practical and theoretical.

Reflecting back on all three projects it was apparent that only a small group actually participated in the projects. Although each of the projects deliberately reached out and connected with many more the core group was still small. These core activists although keen to participate were still wary and guarded about the longer term outcome. Some of them had engaged in previous projects and were concerned that this would be yet another such project. Also, they were the core activists and realised that many of their peers were much more reluctant to participate.

This hesitancy on the part of others alerts us to the importance of the broader social and material context within which they lived. In themselves such arts projects cannot change these circumstances but they can perhaps

build confidence and allow people to reflect more upon their circumstances.

Recently, in an article on the power of music to transform our way of thinking Ed Vulliamy (2009) commented

‘Can a drop of water punch a hole in a rock? No. But the Colorado river gouged out the Grand Canyon. Songs cannot change the world, but enough good protest song, enough cogent protest song, can change the landscape.’

In themselves the projects do not offer transformation but, as Vulliamy argued, perhaps they can help change the landscape such that more fundamental change can occur. These three studies were small but showed the capacity to engage marginalised groups in a process of challenge through collaborative arts projects.

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