

This book is dedicated to

Ian Craib

Preface

This book is based on papers presented at a second one-day conference hosted by the Narrative and Memory Research Group at the University of Huddersfield. The conference was held in May 2002 and was entitled 'Narrative, Memory and Health'. The Narrative and Memory Research Group has been running for five or so years with members from the disciplines of both psychology and sociology. When establishing the Group we placed the emphasis on providing a forum for researchers in the Division of Psychology and Sociology to share ideas in a friendly and supportive setting. The two conferences organised to date aimed to reflect this ethos and have enabled researchers to come together from across the United Kingdom and beyond to discuss and develop their interests in narrative research and theory.

Once again the conference was a resounding success. It would be easy for members of the Group to take credit for such a well-organised and welcoming event. Alas we must resist such temptation and firmly acknowledge the patience, good humour and meticulous attention to detail of Liz Senior in the Conference Office.

Acknowledgements

First we would, once again, like to thank all those people who participated in the conference and in particular those who have taken the time and effort to produce a version of their paper for this book. As you might expect, with work in this area, it is also necessary to offer our thanks to all those people who participated in research that forms the basis for many of the chapters in this collection.

Organising a conference is a huge responsibility and a somewhat stressful time. Therefore we would like to thank our colleagues in the Department of Behavioural Sciences, in particular the postgraduate students, for their practical assistance and invaluable contributions both in terms of planning the event and ensuring smooth running on the day. Finally, Susan Smith has once again been responsible for transforming the text of versions submitted into the polished artefact. As usual Susan a job well done - thank you.

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Introduction

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Narrative and Health

Becoming ever more apparent is a growing interest in narrative theorising and research in a range of health arenas, for example: nursing (Buchanan, 1997), primary care (Launer, 2002), psychotherapy (Payne, 2000; McLeod, 1997), bioethics (Lindemann Nelson, 1997). Launer (2002) pauses to consider the changing landscape where in the recent past phrases like ‘narrative’, ‘postmodernism’ or ‘social constructionism’ meant very little to most practitioners. He contrasts this with the present where the medical press has become ‘full’ of articles that are inclusive of such terms. Indeed there is a core text on narrative-based medicine (Greenhalgh and Hurwitz, 1998). Why might this be?

In conversation Jerome Bruner (2002) talks about the *plights* that we all inevitably face throughout our life course. He de-stabilises the notion of being a ‘patient’ with the view that we are people with *plights* - human beings. We have expectations about our lives and often, all of a sudden, things happen differently. Bruner says that we try to cope, to restore new legitimacy and expectancy in life. It is suggested to him that the self is a ‘series of stories’; to this he thoughtfully replies ‘certainly a library of stories’. This comment prompts his reflection on the origins of narrative structures; can these be located in language or culture? Interestingly in response to his own reflection he says ‘I don’t know, it doesn’t matter’. What he says ‘does matter’ is that we try to see and understand the narrative structures that characterise people’s lives. Here then might be the reason why there has been a wealth of interest in narrative. No longer is the professional presented as having a monopoly on describing people’s experiences. Here there is an acceptance of the need to look at how people actually live and make sense of their lives.

Narrative Processes

When making an attempt to impose some semblance of structure upon the varied chapters submitted for this collection we decided to utilise Polkinghorne’s (1995) phrase of *narrative configuration*. This term is used to refer to the process by which ‘... happenings are drawn together and integrated into a temporally organized whole’ (p.5). With narrative configuration

attention is given to the plot and the way in which different aspects of a story are integrated to form something that is more unified and complete. Most writing on narrative offers an account of human experience that has a temporal dimension with a beginning, middle and an end; often there is resolution, a valued endpoint, a moral. The accounts that are told therefore make themselves relevant to the endpoint thus forming a plot with events ordered in a linear temporal sequence, these being causally linked. Thus we are confronted with the 'good story' creating the impression of coherence and direction (Gergen, 1997).

Often such processes are presented as mere conventions of communication. Such conventions can possibly limit or even disavow the experiences that can be told. Indeed Becker (1999), when researching narratives of pain in later life, makes reference to 'startling', 'incoherent' and 'disjointed' accounts (Becker, 1999). In the first section of this collection there are several chapters that provide opportunities to look beyond the 'good story' to explore and engage with debates and dilemmas that may have no resolution - no endpoint. Rather they ask the reader to consider the implications of narrative configuration both for the individual and personal experience but also for narrative inquiry and its plausibility and 'explanatory power' (Connelly and Clandinin, 1990).

We begin this year's collection with Ian Craib's contribution entitled 'The unhealthy underside of narratives'. In this chapter he extends previous work (Craib, 2000) where he reflects on narratives as a form of bad faith. As some of us have commented previously (Horrocks and Kelly, 2002) the idea of narratives as bad faith goes some way toward exploring why we might tell particular stories. Brought together is Sartre's ethical position of 'bad faith'; and choices made at the 'reflective' or 'pre-reflective' level, with Freud's unconscious drives. Each of these, he says, shares the status of being open to denial. What he goes on to suggest, and demonstrate through the sociology of emotions, is that all personal narratives are to some extent bad faith narratives. For Craib, emotional life is 'complex and contradictory and too disruptive to be grasped in a coherent way ...' (2000, p.71), thus we tell ourselves stories to 'ease our anxieties'. Here, drawing upon his work as a psychotherapist and his own personal life, Craib begins to make inroads into the counter productive nature of some narratives. He refers to 'slippage' in the use of narrative where meaning creation and causal explanations, which are often distanced from the individual, become somehow reconciled. Craib sensitively takes the reader on a journey that questions the utility, and possibly the futility, of coherent narrative configuration; that may indeed masquerade as a full explanation. Returning to his earlier work on bad faith he asks us to consider individual meaning making and how this might be compromised when we adopt shared cultural narratives. Carefully woven throughout is his reflection on the human condition where Freud's disorganised unconscious is contrasted with the progressive, connectedness and coherence of narrative configuration.

The chapter by Roberts on 'Health and Recurrence' presents further complexities around narrative configuration. Recurrence introduces a temporal dimension where the narratives we construct are subject to 'repetition' and revision. Unlike in the previous chapter by Craib we seem to be presented with an individual who is actively engaged in 'rewriting the self' (Freeman, 1993). In what appears to be a similar track Smith and Sparkes offer another encounter with coherence outlining Mishler's (1999) view that it is an ambiguous concept that manages to defy precise definition. Nevertheless, they move on to explore *narrative practices* illustrating the difference between the *hows* and the *whats* of storytelling. Using the life story of Doug, a man who experienced a spinal cord injury, we are shown a range of narrative practices that enable him to *do* coherence. In this chapter coherence is presented as an 'artful' endeavour where things that may be incoherent are imbued with coherence. This is not presented as unproblematic and the disempowering possibilities of reproducing culturally preferred stories are presented as a cautionary note. Taking up coherence and narrative practices as disempowering the chapter by Gurbutt on Sudden Infant Death Syndrome (SIDS) describes how an incoherent description develops into a story that is refined and edited in the retelling. Here the role of the audience is clearly brought into view where mothers feel the necessity to tell certain 'acceptable' stories. Importantly, also evident are spaces where, with the telling of specific 'maternal' stories, the women feel able to grasp an opportunity to take control and assert themselves as good mothers. The concept of coherence provides something of a backdrop for Reynolds' chapter on the function of 'always' for women living with multiple sclerosis (MS). Here 'always' is seen to serve the dual function of accommodating and resisting change (Mishler, 1999). The women use 'always' to maintain continuities in their identities often using the term to refer to the pre-illness self.

Culture, Context and Personal Narratives

Langellier (1989, p.261) explains that telling personal narratives 'does something' in the social world; they participate in 'the ongoing rhythm of people's lives as a reflection of their social organisation and cultural values.' Here the stories that are told are seen as embedded within larger social processes. The personal narrative moves from a *unit* of discourse to a *type* of discourse among other types that constitute the talk of a culture (Langellier, 1989). Therefore in this second section we are compelled to consider the multiple contexts of personal narratives; what might inform and/or constrain our storytelling.

In Throsby's chapter we are asked to consider the social and cultural resources available for those who have *in vitro* fertilisation (IVF) treatment that

then fails to comply with the happy ending of a successful pregnancy. Throsby maintains that they occupy a 'liminal' space between conformity to, and transgression of, normative reproductive values. Presented here is a thought provoking account of how the pathologising of infertility can have the outcome of locating 'non-motherhood as a signifier of disorder in women.' Baldwin's chapter examines the ways in which 'narratives of guilt' are constructed in cases of alleged Munchausen Syndrome by Proxy (MSbP). He presents a persuasive account that describes a context where women are constantly confronted with obstacles that make it difficult to challenge accusations made against them. In this context any alternative 'narrative of innocence' seems to go unheard.

Nicolson's, and Milnes and Horrocks' chapters, both explore the context in which women enact their early sexual experiences. Nicolson reflects on a context where we might have had expectations of greater sexual permissiveness and knowledge in light of the sexual revolution of the 1960s and beyond. Yet her research reveals that the cultural context is one where female sexuality remains locked into narratives that firmly locate and constrain sexual horizons. Utilising Taylor's (1989) work on communities and cultures Milnes and Horrocks explore pre-adolescent and adolescent sexual relationships. Presented is a 'contextually grounded' interpretation of Abby's life story. Her personal narrative is seen to be informed by dominant cultural and community narratives. Abby's story is suggestive of successful resistance from constraining narratives of gender-appropriate sexual behaviour. Such optimism is short lived with a story of resistance swiftly being usurped with one that has undercurrents of collusion and another characterised by passive surrender.

Such values and constraints are not limited to those who render their personal narratives, they are shown to be part of ongoing methodological debates and practices. The impact of a discourse of validity and reliability, on life history as a legitimate and valuable research method, is initially discussed by Dyson. She moves on to effectively explore the life histories of Zimbabwean nursing students studying in the UK. These life histories are set within a complex web of racial, professional and interpersonal processes. Similarly, Thurgood asks us to critically reflect and consider our ethical stance in relation to oral history archives. The changing legal context and its implications with regard to informed consent and the protection of third party interests is given a thorough airing. An oral history project with retired nurses is drawn upon to make visible the deliberations and dilemmas confronted when making decisions about both the research process and data archiving.

The two remaining chapters in this section feature biographical research undertaken with older women. In these chapters we are given the chance to explore the interaction of individual biographies, health care practice and social and cultural locations. Birren et al. (1996) maintain that:

Aging need not be understood in bifurcated terms, as either enhanced infirmity or enhanced wisdom; reflexive biographic and ethnographic study can be important in extending our understanding regarding issues of continuity and change within lives over time. (p.76)

Jennifer Swindle gives us access to two women, Ingrid and Mary, who reside at a nursing home in Ontario, Canada. The women had very different life course experiences culminating in very different 'personal traits'. Such differences in previous personal lifestyle are shown to have significant implications regarding inclusion, empowerment and community. These women seemingly experienced the same environment yet their divergent stories enhance our appreciation of the interaction between context and personal biography. The final chapter by Chambers seeks to understand the ways in which older women make sense of changing health circumstances. This making sense is set within the context of their individual and collective life course but also within the context of 'growing old in an ageist society'. Again it is shown that personal biography and an understanding of the whole life course is central to any comprehensive understanding.

References

- Birren, J.E., Kenyon, G.M., Rauh, J., Schroots, J.J.F and Svensson, T. (eds) (1996) *Aging and Biography: Explorations in Adult Development*, New York, Springer Publishing Company.
- Becker, B. (1999) Narratives of pain in later life and conventions of storytelling, *Journal of Aging Studies*, 13,(1), p.73-87.
- Buchanan, T. (1997) Nursing our narratives: towards a dynamic understanding of nurses in narrative tales, *Nursing Inquiry*, 4, p.80-87.
- Bruner, J. (2002) Narratives of human plight: a conversation with Jerome Bruner, in Charon, R. and Montello, M. (eds), *Stories Matter: The Role of Narrative in Medical Ethics*, London, Routledge.
- Craib, I. (2000) Narrative of bad faith, in Andrews, M., Sclater, S.D., Squire, C. and Treacher, A. (eds) *Lines of Narrative: Psychosocial Perspective*, London, Routledge.
- Connelly, F.M. and Clandinin, D.J. (1990) Stories of experience and narrative inquiry, *Educational Researcher*, 19 (4), p.2-14.
- Freeman, M. (1993) *Rewriting the Self: History, Memory, Narrative*, London, Routledge.
- Gergen, K. (1997) *Narrative, Moral identity and Historical Consciousness: A Social Constructivist Account*, <http://www.swarthmore.edu/SocSci/kgergenl>.

- Greenhalgh, T. and Hurwitz, B. (1998) *Narrative Based Medicine: dialogue and discourse in clinical practice*, London, BMJ Books.
- Horrocks, C. and Kelly, N. (2002) Making sense: exploring diverse lines of narrative, *Feminism and Psychology*, 12 (3), p.
- Launer, J. (2002) *Narrative-based Primary Care*, Abington, Radcliffe Medical Press.
- Langellier, K.M. (1989) Personal Narratives: Perspectives On Theory and Research, *Text and Performance Quarterly*, 9 (4), p.243-276.
- Lindemann Nelson, H. (ed) (1997) *Stories and Their Limits: narrative approaches to bioethics*, London, Routledge.
- McLeod, J. (1997) *Narrative and Psychotherapy*, London, Sage.
- Mishler, E.G. (1999) *Storylines: Craftartists' Narratives of Identity*, London, Harvard University Press.
- Payne, M. (2000) *Narrative Therapy*, London, Sage.
- Polkinghorne, D.E. (1995) Narrative configuration in qualitative analysis, in Amos Hatch, J. and Wisniewski, R. (eds), *Life History and Narrative*, London, The Falmer Press.