**Chapter 13**

**Promoting health through narrative practice**

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**Summary**

This chapter places narrative practice at the centre of discussion about promoting individual and collective health and wellbeing. Narrative practices in health care are characterised by the use of stories in an empathic and professional way. This involves narrative competence of professionals to “listen, recognize, absorb, interpret, and be moved by these stories” (Charon, 2006). Some basic assumptions guiding narrative practice are derived from narrative theory. 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 addition to identity construction and making sense, narratives perform many functions, such as remembering, arguing, justifying, persuading, engaging, entertaining, misleading, mobilizing others, fostering a sense of belonging, connecting people (Riessman, 2008). Narratives are also shared at a social level such that we can have stories about families, communities and societies. Health and illness are enmeshed in these narratives such that narrative practice can become a guide to health and wellbeing.

**Introduction**

During the last years a wide variety of approaches has been developed that recognize the role of narratives in different settings in somatic and mental health care. Promoting health through narrative practice always entails a change in meaning and identity, which is accomplished through storying life in various ways: telling, writing, or showing through arts projects. Our overview of examples in this chapter is not comprehensive, but intended to illustrate the variety of narrative practices in health care. While recognizing that narrative always operates at both the individual and the collective level, we start the chapter with examples from narrative practice aimed primarily at personal change, followed by examples of narrative practice directed at the collective and community level.

1. **Personal change**
   1. ***Narrative therapy***

It can be argued that all psychotherapy is narrative in the sense that storytelling is always somehow part of therapy sessions (McLeod, 2008). In this section, however, we focus on narrative therapy in the specific sense, as developed by Michael White and David Epston (1990) by bringing different bodies of literature together. Departing from a common background in family therapy, White and Epston got introduced to Bateson’s interpretive method:

“The interpretive method, rather than proposing that some underlying structure or dysfunction in the family determines the behaviour and interactions of family members, would propose that it is the meaning that members attribute to events that determines their behaviour”.

Not only does the interpretive method change the focus in psychology from underlying mechanisms to meaning, it also foreshadows a change from dysfunction to positive functioning. From Bateson they also learned about the importance of the temporal dimension in therapy (ibid, 1990). Michel Foucault’s work on power and knowledge then led them to “considerations of the constitutive role of cultural knowledges and practices”(White, 2004). However, it was the concept of narrative that allowed them to integrate these different bodies of literature into one coherent framework that they considered very much suited for therapy.

"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” (White and Epston, 1990, p14).

They argued that not only are certain stories at the basis of problems people experience but that it is through restorying life that people can ‘inhabit’ life again. This restorying is accomplished in a process by which problem-saturated descriptions (also referred to as thin stories) are transformed into thick descriptions (or thick stories). This transformation is a complex process, that in a nutshell consists of two main processes, e.g. 1) externalising the problem and 2) developing alternative stories. These processes are guided by various narrative practices. White maps possible narrative practices in a very insightful book *Maps of Narrative Practice* (2007), in which he discusses externalizing conversations, re-authoring conversations, re-membering conversations, definitional ceremonies, conversations that highlight unique outcomes, and scaffolding conversations. For the purpose of this chapter, we suffice with a brief description of externalising conversations (aimed at externalising the problem) and definitional ceremonies (aimed at enabling endurance and expansion of alternative stories) in the remainder of this section.

*Externalising the problem*

Externalising the problem through externalising conversations is a crucial element of narrative therapy. In the author’s own words:

“Rather than considering the problem as being required in any way by persons or by the “system,” I have been interested in the requirements of the problem for its survival and in the effect of those requirements on the lives and relationships of persons” (White & Epston, 1990, p3).

One powerful way of externalising the problem in narrative therapy is through endowing the problem with human characteristics and thus allowing clients and others in their social system to relate to the problem. Perhaps one of the most imaginative examples of this process of endowment is the case of Jeffrey, a little boy who is brought by his parents to Michael White for help because of his ADHD diagnosis (White, 2007, p10-23). In a focused series of questions, Michael manages to get Jeffrey, who is until that point quite disinterested and distracted, to become enthusiastic and curious about what his ADHD looks like. Consequently, the boy offers his own idea of finding out more about him:

Jeffrey: “I will wake myself up in the middle of the night and take a picture of my AHD before it jumps back into me! I will. I’ll do it. (*At this point I discovered that Jeffrey always dropped a D out of this description. He didn’t have ADHD after all, but AHD.*)”

This example illustrates how, literally, the problem becomes externalised. Instead of perceiving Jeffrey as *being* the problem or as *having* a problem, the problem now is a separate entity who he can observe and to whom he and his parents can relate. White’s remark in brackets is indicative of another feature of narrative therapy, that the client is considered to be the expert about his own life, not the therapist.

*Definitional ceremonies*

Definitional ceremonies are rituals, which:

“acknowledge and ‘regrade’ peoples’ lives…[and] provide people with the option of telling or performing the stories of their lives before an audience of carefully chosen outsider witnesses. These outsider witnesses respond to these stories with retellings that are shaped by a specific tradition of acknowledgment” (White, 2007).

As this example shows, narrative therapy does not only takes place in individual talking sessions, but engages, if so desired, significant others in the client’s life. Narrative practice is thus a thoroughly relational practice. The example of definitional ceremonies also shows how narrative therapy is not merely learning how to tell another story, but a narrative practice in which stories are developed that matter in life and relationships. The ritual organizes the vital yet enduring uptake of healing narratives by embedding newly developed stories within a specific tradition.

Finally, written documents have from the outset been an important ingredient of narrative therapy. These documents include both letters produced by clients and so called counter documents (certificates or diploma’s, and declarations) which as usually written by the therapist. Two letter examples are redundancy letters (letters that make people redundant in roles such as “parent watcher” or “brother’s father”) or letters of prediction (letters that project the future life after therapy). Counter documents are used as “recognition of the client’s accomplishments”(Lebow, 2008). What all these documents have in common is “that they strengthen the alternative stories that emerge in therapy” (ibid).

*Narrative therapy as critical health psychology*

Narrative therapy is quite explicitly a form of critical health psychology. First, by paying attention to how dominant narratives shape individual lives, and focusing on the development of alternative stories, the dominant individualistic focus in mainstream psychology and therapy is countered. Moreover, in recent constructivist approaches to narrative therapy, this point led to the acknowledgement that perceptions of therapy itself are socio-historical constructions, and thus in need of critical appraisal. Second, by employing folk psychology, narrative therapy aligns with a psychology of mind rather than with the continuing popularity of neuropsychology and behaviourism. Third, by prioritizing the client as expert, narrative therapy counters the dominance of the therapist as expert and thus honours the client-centred tradition. However, White and Epston distance themselves from “the conception of a ‘self’ as an essence that is understood to occupy the centre of personal identity” which arguably is central to a Rogerian quest for a core, authentic self. Instead, they approach identity and authenticity as multiple, which is in line with constructivist approaches.

* 1. ***Narrative writing practices***

*Expressive writing*

In his book *Writing to Heal* (2004), James Pennebaker promotes expressive writing as a guide to recover from trauma and upheaval. Expressive writing is based on the idea that worse than experiencing trauma, is keeping trauma a secret. Pennebaker (2004) situates expressive writing historically as a form of emotional writing, thereby emphasising the importance of expressing emotions regarding the trauma and upheaval rather than mere description. The written form of this therapeutic tool serves the open and honest expression of emotions to oneself without fear for audience responses. More recent e-health applications of this tool build on the advantages of anonymity for the free expression of emotions, while enabling minimal therapeutic guidance (Lamers et al., …). Although expressive writing can benefit all types of people, it appears to be the most beneficial for “hostile, out-of-touch men…because they are the least likely to open up and talk with others” (ibid, p10).

The general instruction for expressive writing is to write for a minimum of four consecutive days, and continuous for at least twenty minutes a day (Pennebaker, 2004). The writer can choose to write about the same topic or about different topics each day, is warned to “deal only with those events or situations that you can handle now”, and is informed to expect possible sad or depressed feelings as a direct consequence of writing (ibid, p26). The writer is encouraged to write “about your deepest thoughts and feelings about the trauma or emotional upheaval that has been influencing your life the most”. In addition, in the instruction the writer is prompted to create a narrative account by suggesting possible connections of the event to other parts of life and to relationships, but also by suggesting temporal connections.

“Above all, how is this event related to who you were in the past, who you would like to be in the future, and who you are now?”

Each writing session ends with an evaluation of how writing affected the person.

In addition to the general instruction, specific exercises are offered to stimulate processes that are considered to be effective for healing purposes. These processes include: appreciating the good in a sometimes bad world; constructing a meaningful story; changing perspectives; experimenting with context; and writing creatively. A noteworthy example of creative writing is the construction of imaginary stories, because this example challenges the idea that therapy should be about events that really happened instead of about fictitious events. in this exercise, the person is encouraged to write in an engaged way about an imaginary traumatic experience that “ideally …is the *least* relevant to your life” (Pennebaker, 2004, p141).

*Autobiographical writing*

Autobiographical writing is a written form of life-review, i.e. a structured form of reminiscence (remembering the past) that focuses “systematically on the entire lifespan and promote[s] the evaluation and integration of positive and negative memories” (Westerhof et al.). Autobiographical writing has been developed both for therapeutic and creative purposes (Bohlmeijer, 2010). In addition to personal autobiography, guided autobiography groups have been developed such as the one by Birren and Cochran (2001). A specific form of autobiographical narrative practice developed for older persons in nursing homes are so-called lifestory books, which are made in co-production by residents, their family members and caretakers (Huizing & Tromp, 2007).

Guided autobiographical writing is typically structured temporally, guiding writers from past to present to future. In addition, writing exercises in a specific order can be part of autobiographical writing. These guidelines about narrative content and sequence, derived from insights from life-review research, are focused on optimizing the change of meaning and identity. For example, participants are asked to write stories of negative memories, followed by an exercise to find alternative explanations for them. And participants are asked specifically to write about positive experiences, thereby countering the overall negative life-story in which agency is experienced as minimal.

*Narrative futuring: Letters from the future*

Narrative practices based on looking back have long dominated psychotherapy and health care, at the expense of looking forward (Sools & Mooren, 2012). An explicit focus on the future can be found in narrative futuring, i.e. imagining the future through stories (ibid). One specific instrument to engage narrative futuring are letters from the future (Bohlmeijer et al. 2007). This mental health promotion instrument can be used in groups and individually, and is considered to have a positive effect on well-being and resilience (Sools, Mooren & Tromp, 2013). The instruction is to imagine going in a time-machine to a moment in the future of the writer’s own choice, and to imagine as vividly as possible a particular situation in which something posi­tive has been realised. The writer then is invited to write a letter to some­one in the present, telling about this positively experienced situation. The following example letter is derived from a web-based study conducted in 2011 and 2012 (Sools & Mooren, 2012):

*2011, reading behind the computer in my office at the university.*

*Honorabel Me,*

*Hey Me, cool that I bump into you, the fact is that I want to tell you than I am re­ally proud of us. The way you nowadays respond to your duties, assignments and other responsibilities, not postponing them any longer, gives me an intense feeling of love for you, and thus for myself. I still remember well how difficult this was ten years ago. You were very talented in avoid­ing your responsibilities. That came in han­dy for momentary pleasures, but if you had persisted in it, it would have been a disaster for your long term happiness.*

*So, cool that you became how I wanted to be, we fixed that nicely.*

*Greetings (I don’t give you a smacker, no idea how one takes it nowadays, but in 2011 it is still a bit weird to kiss oneself)*

*You, byyyy .*

Sools, Mooren and Tromp (2013) use this letter to illustrate possible ways of working with the letters from the future in a therapeutic process: stimulating reflection about the desired, valued self (in this letter a person who takes responsibility); motivating current action and thought(encouragement to take on a difficult challenge the person faces); realizing, i.e. making real, a future possibility in order to experience whether this future fits the person or not; facilitating anticipation to an unknown future by imagining multiple scenarios; restoring disrupted experience of time, for example in case of anxiety for the future (a nearby, relatively easy to reach future such as in the example letter might be more beneficial to persons with depression than distant goals); reflecting on and strengthening the immediate effects of writing the letter, such as joy, optimism, hope.

* 1. ***Summary***

In sum, we can now distinguish five dimensions along which the narrative practices described in this section can be categorized. First, the extent to which these practices use narrative theory to guide therapeutic interventions, with narrative therapy being the most explicit in its narrative theoretical underpinnings. Second, practices differ regarding the extent to which they make use of structured instruments: ranging from a general outline with considerable freedom in structure, form and content, to more focused exercises, to programmes with exercises in a specific order. Third, practices vary in time perspective: autobiographical and life-review methods encompass the entire life-story of a person; expressive writing focuses more on specific (past) traumatic events that are relevant for the here and now; letters from the future construct a desired future life; narrative therapy integrates past, present and future but varies in the extent to which the whole life-story is taken into account. However, all practices share the assumption that writing about life is a constructive act, whether it is the past or the future to be reconstructed in light of present concerns and wishes. Fourth, narrative practices differ with respect to the role of guidance in relation to how explicit the therapeutic goal is: narrative therapy clearly involves a therapist; expressive writing and narrative futuring can be used as self-help instruments, sometimes with minimal guidance; autobiographical writing typically takes the shape of a guided course, whether used as creative course or as mental health promotion instrument; life-review is usually a guided narrative practice. Fifth, narrative practices vary to the extent that they make use of different creative modes: autobiographical practices, life-review and narrative futuring rely often but not necessarily on written narrative; narrative therapy uses a variety of creative means.

1. **Collective narratives**

Introduction

* 1. ***Historical and social psychological***

Narratives are not only told by individuals but also shared by communities and societies. In the same way that narrative is said to shape the identity of the individual it can also be said to shape the identity of the collective. In this section we will consider the character of narratives shared by members of a collective, how they are connected with various social representations, how they are involved in social actions and underlie social and health movements. At the outset we should distinguish collective narratives from the term ‘social narratives’ which is used to describe an approach developed by narrative practitioners working with people who have autism. In that context the term refers to a type of visual social script which the client is taught to use in particular problematic social settings. The collective narrative that we will discuss refers to the shared narratives held by some collective whether it be a family, an organisation, a neighbourhood, a social category, or a nation.

The historian Hayden White (1973) placed narrative at the centre of his historiography arguing that while a chronicle was a basic temporal listing of events a story provided a certain organisation to this sequence and developed an explanation of past events through the process of emplotment. Historians have also invoked narrative as one of the organising forces of national consciousness. It can detail experiences of oppression and resistance which become part of who we are. For example, the historian Roy Foster (2001) in his account of the role of narrative in shaping “The Irish Story” details the many different stories with their ‘heroes, villains, donors, helpers, guests, plots, revelations and all the other elements of the story form’ (p. 2). Of particular note in the Irish context is the role of the arts in shaping the national story. Kiberd (1996) has detailed the role of many great Irish literary figures in defining what is Ireland and what it is to be Irish. He notes:

‘Ireland after the famines of the mid-nineteenth century was a sort of nowhere, waiting for its appropriate images and symbols to be inscribed in it’ (p. 115).

In the early 20th century, the poet W.B. Yeats was to the fore in defining the new Irish national consciousness rooted in the concept of a distinct national story. These stories challenged the dominant British imperial narrative and led to the rupture with Britain signalled by the Easter Uprising in 1916 which in its very structure had an almost theatrical form with events located at different points throughout Dublin not because of their military importance but more for their dramatic effect. The dramatic nature of these events contributed to the development of the collective narrative of resistance and liberation.

Social psychologists have recently begun to explore their connections with history and the historical nature of the discipline. In particular, several social psychologists have considered the role of narrative in shaping collective memory and identity. This process is summarised well by Liu and Hilton (2005: 537):

‘History provides us with narratives that tell us who we are, where we came from and where we should be going. It defines a trajectory which helps construct the essence of a group’s identity, how it relates to other groups, and ascertains what its options are for facing present challenges’.

These historical narratives integrate and organise individual and group experiences. They provide a shape to the history of communities and nations but also to our everyday practices. As Jovchelovitch (2013) wrote:

‘They convey and by the same token produce and reproduce, the traditions, the practices, the mythologies, and the accumulated wisdom of human communities. They live in our collective memory and in the institutionalised rituals we draw upon to reproduce our social and cultural lives’ (p.3).

Thus narratives are not just symbolic creations but take on material character in our everyday social practices. These narratives are not fixed but are shaped in everyday social interactions. They can reflect and shape both communities of identity and of place and a combination of these. For example, Steinmetz (1992: 489) considered the role of narratives in forging working-class consciousness. He argued that the ‘elaboration of coherent narratives about individual and collective history’ provides a means of developing a strong working class identity which is rooted in time and place and which is celebrated through accounts of struggles to overcome adversity.

These collective narratives draw upon and reproduce broader social representations or shared meaning systems of the nation or other phenomena. Lazslo (1997, 2008) and others (Murray, 2002; Jovchelovitch, 2013) have argued that the very process of exchanging stories provides the foundation of social representations and that social representations have an underlying narrative structure. As Jovchelovitch (2013) claims: ‘the narrative form provides a core structure to a representational field, bringing together and investing with meaning the various notions, values and practices it contains’ (p.6).

Laszlo (1997) has considered the underlying narrative structure of the social representations of health and illness detailed by Herzlich (1973). In Herzlich’s study she conducted interviews with a sample of lay people but in her analysis ‘instead of taking into account the storied nature of the explanations, concentrated exclusively on the categorical anchoring and objectification of health’ (Laszlo, 1997:163). Murray (2002) further considered Herzlich’s description of the social representations of illness in terms of liberation, occupation and destruction and compared them with the classic narrative tropes of romance, comedy and tragedy. He argued that the social representation of illness reflected these narrative forms. Thus the social representation is not a set of abstract categories but one filled with emotions and values contained in the narrative form.

While certain collective narratives seem to maintain their currency others fade with time. We live in a world of conflicting narratives which can promote acceptance or challenge of existing social arrangements. Their stability depends upon the extent to which they connect with contemporary social representations, or as Jovchelovitch (2013) states:

‘The stickiness of stories over time relates to the internal architecture of social representations and how specific patterns of signification are arranged for mobilising commitment to imaginations, projects and courses of action’ (p.6).

Further, the emotional content of narrative accounts of past oppression can still linger after the circumstances have changed. It is these historical narratives which are used to help define collective identities and to distinguish one community from another. Developing a shared narrative of change is a challenge for political as well as community leaders.

* 1. ***Community narratives***

Currently there is much discussion about the nature of communities and the role of critical health psychologists in these settings as discussed later (Chapter 14). Here it is sufficient to briefly consider the role of narratives in understanding the dynamics of communities. Community narratives are the stories residents of a particular neighbourhood share about the nature of their community. In one early study, Norbert Elias (Elias and Scotson, 1965/1995) argued that one of the features of working class communities was how they draw the boundaries separating their community from neighbouring ones which were often portrayed as problematic. By doing so they boosted their own collective self-esteem in the way that Tajfel later described in his social identity theory (Tajfel et al, 1971). Similarly, in their contemporary study of a working class community Rogaly & Taylor (2009) noted how the residents identified very closely with their own neighbourhood which it was argued was ‘often based on self-distancing from another’ (p. 5).

In our study of a disadvantaged working class community (Murray & Crummett, 2010) we found that the older residents similarly portrayed it as distinct from neighbouring communities and that theirs had been neglected and stigmatised by the local council. Many of the participants we interviewed recalled that when they moved into the neighbourhood, the houses had just been built and there was a spirit of togetherness. They presented a narrative of decline in which facilities were gradually reduced or removed and now there was less of a sense of community. The outsider, in particular the local council, was portrayed as the cause of this deterioration. One older man described this process:

‘We’re a forgotten area and always have been. When you get the newsletter it’s all about that end, there’s never anything about us. I think it’s happened because they give us nothing, well that’s how its seems to me ... we have nothing as far as activities or opportunities for older people on this estate ... we’re very much a forgotten area, what you might call the poor relation in comparison to other areas in this ward’ (p. 782).

However, this was not always the case and many of the residents told stories of talent ignored. This was an example of the diversity of the narrative accounts. As one older man said:

‘There’s some good people on this estate, but you see over the years we’ve been stigmatised – them up there, they’re this and that – but it’s a minority that cause the trouble and people seem to forget that’(p. 782).

The residents were aware of the negative social representation of the community held by outsiders but they challenged this with particular narrative accounts of achievement. It was through this process of counter narrative that they could maintain their self-esteem despite ill-health and everyday evidence to disadvantage.

* 1. ***Narratives and social action***

Historians and political scientists have also considered narratives as not just giving a sense of identity to a community but also in orienting it to certain forms of collective action. Previously we noted how a distinctive narrative of disadvantaged communities was that of the ‘forgotten community’ with its accompanying emotions of anger, frustration and demoralisation. This was one of the four narrative structures that Selbin (2010) has argued underlie social movements. The four narrative structures he identified as underlying these movements for change were the Civilizing and Democratizing Story, the Social Revolution story, the Freedom and Liberation story, and the Lost and Forgotten story. He argued that the task of the agent of social change is to develop a compelling narrative that convinces the collective of the possibility of change be it small or large.

This process of connecting the community with a new narrative can be the psychological means of engaging a collective in combating various restrictions and in developing a new life. Polletta (2006) in her study of the role of narrative in social movements described the process as follows:

‘storytelling sustains groups as they fight for reform, helping them build new collective identities, link current actions to heroic past and glorious futures, and restyle setbacks as way stations to victory. Even before movements emerge, the stories that circulate within subaltern communities provide a counterpoint to the myths promoted by the powerful’ (p. 3).

This mobilising potential of narrative is one of its distinctive features. It is not just concerned with describing events but emotionally connecting people with its version of events and also with orienting them to certain actions. Of particular importance is the relationship between the storyteller and the audience. This centres on the audience identifying with the storyteller and in accepting his counter story. This relationship is a step on the road to engaging the community in the process of social change. As Davis (2001) states: ‘Readers/listeners who identify with the storyteller step into the story, recreate the world it presents, and retain the experience. They make, in short, the story their own’ (p. 17).

The story of social change is one which has a clear moral content about righting wrongs and challenging injustice. As such it connects individual advancement with broader social change. Again, Davis (2001) summarises this process:

‘through narratives and narrative models, movements provide new sources and means of identification and recognition. Movements provide characters and a defining moral community, for instance, through which members can reconfigure themselves as moral agents of a particular type and sensibility’ (p. 26).

In the community development project mentioned earlier (Murray & Crummett, 2010) we worked with some of the older residents on a community arts project which resulted in the creation of art works which were subsequently exhibited and reported on in the local newspapers. The reaction of the participants was excitement at their individual and collective achievement which demonstrated their capacity. Instead of a narrative of decline and isolation the art project offered the potential of a new narrative of hope. As one of the participants said:

‘Everybody’s talking about what we’ve been doing. Even the councillors when they come to the meetings. See I don’t think they knew we could do these sorts of things, but then we’ve never had it before, people coming and showing us and giving us a chance’ (p. 783).

In the same study we also conducted interviews with a range of community workers about their work (Murray & Ziegler, 2014). The biographical story they developed had some of the character of the ‘redemptive’ story described by McAdams (2013). A central feature of the story line was giving back to the community from which one had come. The community workers felt that they were in some ways part of a broader movement for social change. The challenge was to convince the residents of the possibility of change. One of the community workers we interviewed put it this way:

‘So selling people this idea of this holistic change, making people believe that something, and at the time I’m still getting to grips with it myself, how are we going to make ... ‘cos I had known that area for a long, long time and I’d grown up not far away from that area, so I kind of believed ... having to make myself believe it and regularly having conversations with people: ‘Do you [...] honestly believe it’s going to work?’ [...] And you go ‘Do you know what, I really think it is.’ That was enough for some people to go ‘Do you know what, I’m going to try and get a resident group set up around here. I’m going to try and get people mobilised.’

Working in these communities the community workers realised the limitations of the individualistic focus on health behaviours which was propounded by various health promotion agencies. The sharing of small stories (Sools & Schuhmann, 2013) with community residents was an important means by which the community worker developed relationships with the community residents such that they began to trust her and share with her their problems which were often not those which were the focus of the traditional health educator:

‘the minute that I go out into the community and talk to people about their issues or their needs in terms of health, very rarely, unless I really push it, is about diet and exercise. … It’s a difficult one and it’s not a simple lifestyle choice. I know everybody will say this, who you talk to, but then if the government or even the organisations are saying, ‘All you’ve got to do is tell people that they can get fit by running round the park! It’s free!’, then it’s a naivety almost. Naivety is probably a kind word for it! It’s very frustrating because that’s not the reality at all, and it’s not, particularly if you’re working in a very poor community with all sorts of pressures on you.’

Instead the community worker tried to take up broader social issues and at the same time try to convince the residents of the potential of a broader optimistic narrative when there are so many structural inequalities. One community worker expressed her frustration at the often limiting and instrumental nature of many social interventions and instead referred to the value of creative activities which may have limited immediate value in terms of employment but much more in terms of individual and community enhancement:

‘That’s why it’s hard to get enjoyment because the things that I’d like to be able to do to help people have a different horizon, err, you know, what would be so bad if somebody from round here decided they were going to be a poet and make their fortune out of being a poet?’

The everyday work of the community worker was selling this new narrative, working with the community to advocate for better facilities. Looking back some felt that perhaps they were idealistic but it was this dream of a better world that underlay their work:

‘At the beginning we started building relationships, that was my job initially, start building relationships – lot of work going out, meeting people, selling the idea that we’re going to get [...] of selling the idea that we were going to turn an area around, you know. That this wasn’t just playing about, tarting up the edges and removing graffiti and putting the odd extra street light in, this was about big holistic change.’

* 1. ***Narratives and health movements***

Narratives can also be used as a guide for wider collective action for health. The same principles underlie health movements as those which are centred around promoting community change. The leadership of such movements have to convince the followers of the potential of change. The example of Martin Luther King’s ‘I have a dream’ speech is often used to illustrate this process of potentiality. It was deliberately written in a religious format that was familiar to his followers and cast the civil rights movement as part of larger moral crusade for a better society for all.

The onset of HIV/AIDS in the 1980s was met by a tirade of abuse in the popular press about the sexual practices of gays and lesbians. This vitriol was coloured with references to religion and the ire of god seeking revenge on the supposedly abberant practices of the gay community. After some uncertainty the public health community retaliated with a campaign which was largely clothed in biomedical language emphasising the importance of condom usage. However, this campaign evaded discussion of sexual preferences.

In distinction to this approach the gay movement began a much more adventurous tactic of promoting a new narrative of sexual diversity – to be gay was something to celebrate not something to hide. There was the devlopment of the gay pride movement and the linking of gay rights with civil rights (Hammack & Cohler, 2009). Coupled with this was was promotion of the awareness that HIV/AIDS was not just confined to the gay community was was also prevalent in the straight community. Organisations such as ACT-UP (AIDS Coalition to Unleash Power) organised a range of social protests to demonstrate the need for political action. For example, some members chained themsleves to the railings of the NY Stock Exchange to protest the high prices of anti-AIDS drugs while others demsonsrated outside St. Patricks cathedal in New York to protest against the Catholic church’s teachings on ‘safe sex’.

Through public celebrations coupled with festivals the gay community widened support for their campaign. In doing so they were developing a new narrative of sexual politics which would serve as a model for other public health campaigns. For example, campaigns to challenge social inequalities in health often focus on individual health related pratices of residents of working class communities. The alternative is to celebrate working class identity and to frame the campaign for health as one of civil rights (Levy & Sidal, 2009). The inclusiveness of this narrative is one that can engage a broader coalition. It also involves the celebration of working class identity through cultural festivals to which issues of health can have some connection.

An example is the work of the Feile an Phobail (People’s Festival <http://www.feilebelfast.com/>) in the nationalist area of West Belfast. This festival was initiated by local people to challenge the outsider respresentation of the community as barbaric and feckless. Instead the festival which has continued for 20 years was a means of celebrating the community identity and empowering the residents take up issues around inequalities in healthcare provison, issues of gender and sexuality, and various health issues. It also promoted the use of sports and leisure facilities in a manner that was empowering rather than restricting as public health campaigns are often perceived. As Davis (2001) concluded:

‘Through their narratives and narrative models, movements provide new means of identification and recognition. Movements provide characters and a defining moral community, for instance, through which members can reconfigure themselves as moral agents of a particular type and sensibility’ (p. 26).

1. **Conclusion**

In this chapter we have considered different forms of narrative including those contained in the stories of people with illness through to the stories of communities which have experienced disadvantage. Our aim was to offer an alternative to the individualistic and mechanistic social cognitive models which have dominated health psychology. Instead through narrative we can begin to develop a health psychology which not only locates health and illness experience within social context but also develops an empowering strategy of change.

**Further Readings**

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* An edition collection which illustrate the role of narratives in social movements.

White maps of narrative practices.

After the pioneering work of White and Epston, many have followed in their footsteps. Guidebooks are now more readily available, and make the complexities of narrative therapy more accessible to a wider audience (Payne, 2006; Morgan, 2000; White, 2004). Applications of narrative therapy for specific groups have been developed. Particularly noteworthy is narrative exposure therapy – NET - (Jongedijk, forthcoming), a combination of behavioural exposure therapy and narrative therapy. NET is developed for people who experienced severe trauma such as refugees with a history of violence and abuse, members of police who have been confronted with violence during work, and war veterans.

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