1 Narrative Gerontology: Four Dimensions

This chapter emphasizes the following competencies:

Students will

- use critical thinking to synthesize and communicate information;
- use research evidence to inform practice; and
- plan to engage in practices that advance social and economic justice.

The Narrative: A Scientific Approach

This chapter describes the various uses of the narrative and explains how a narrative may help supply research data and clinical information.

In the late 19th and early 20th centuries, researchers developed a scientific interest in life stories, emphasizing the link between *personality* (or enduring characteristics of the individual such as self-esteem) and *social structure* (or normative characteristics of social systems such as roles and norms) revealed in people's life stories (Ryff, Marshall, & Clarke, 1999). Social scientists then studied people's internal views of their lives and their relationship to the social view of the self (Cooley, 1902/1964; Mead, 1934).

Narrative gerontology developed during the late 20th century as a scientific approach to human development, a field of research that explores the lives of older adults through storytelling. As such, narrative gerontology offers a perspective or a way of gathering new insights on aging (Kenyon & Randall, 2001). The approach is now used in theory building, research, and practice.

One advantage of the narrative is that it is an expression of how people have functioned during their lives, providing the researcher with information or "data" about the aging process (Kenyon, Clark, & de Vries, 2001, p. xii). From this perspective, older adults' subjective memories may offer knowledge about the human condition and thus can be considered part of a qualitative approach to the scientific method.

Each person's story is deemed unique and is accepted at face value. Although the purpose of obtaining a narrative is to retain each person's "voice," when conducting a study a researcher may aggregate information from several life stories, putting the "pieces" together (Bluck, 2001). In this way, details drawn from several life stories may help readers to understand both the individual and the collective meaning of societal issues such as discrimination and oppression.

Narratives as Stories

In the simplest terms, a narrative is a story or the relating of events by one person to another (Birren, 2001). Stories encompass characters, plots, and themes. They are memories of past events, and meanings are attributed to them. Usually, storytellers describe the "best" and "worst" of times. They are able to place themselves in history, give meaning to past events and remembering and aspire to goals in the future, often imagining "future selves" (Markus & Nurius, 1986).

A *narrative*, then, is a story or a person's account of life events, an interpretation of how he or she has experienced life events. Sometimes the storyteller feels a sense of regret. We have chosen storytellers who have perceived positive outcomes despite the adversities of discrimination and oppression during their lifetimes. As we read their personal histories, we find out that they have righted old wrongs, reconciled with their "enemies," take pride in their accomplishments, and feel that they have done their best. The accounts of their lives also provide us with knowledge and values useful for composing our own lives (Butler, 1968).

Constructing stories and interpreting their meaning is a universal human capacity (Birren, 2001). In fact, the process of telling one's life experiences to another is as old as history itself. This process, reflected in poems, drama, oral histories, and, of course, autobiographies, continues to provide people with cultural, social, historical, and recreational benefits.

Narratives as Culture and Social Systems

There are rich differences in people's experiences and the expression of their stories. This is because stories are influenced by the multiple social systems and cultures that affect human development (Webster, 2001). *Culture* is a way of life that binds a community together. It may be understood as "people's shared cognitive map, their discourse, and how they go about their lives—their life perspective" (Greene, 2002, p. 246). Because culture binds a community together and offers a set of norms and values, it has the potential to shape the storytelling process. Therefore, one can expect stories to reflect shared values, beliefs, and expectations of a given society (Webster, 2001) and the "collective thought process of a people or culture" (Cross, 1998, p. 144).

In this text, we use two conceptual frameworks to organize the various social systems described in the narratives. First, life stories are examined as the ecological systems in which people live. Ecological systems include small-scale *microsystems*, such as families and peer groups; midrange *mesosystems*, such as senior centers and the workplace; and *macrosystems*, or the legal and political systems that enact and administer policies affecting such things as discriminatory practices (Kirst-Ashman & Hull, 1993). Thus, the reader can understand social justice issues and resilience at each ecological level.

The second organizing framework used to explore the narratives is that of Kenyon and Randall (2001), who suggested that there are four dimensions of life stories (see Figure 1):

1. The *personal* dimension of narratives provides insights into the subjective world of the storytellers. It allows one to understand the inner meaning of their lives, contextualized in terms of culture, gender, class, and ethnicity (McAdams, 1996). In addition, the personal dimension demonstrates ways in which older adults achieved their own personal goals and exhibited strengths such as perseverance and determination.

Figure 1: Four Dimensions of Life Stories

Source: This figure was created by Dr. Sandra Graham and is used with her permission.

2. The *interpersonal* dimension involves storytellers' relationships with family and peer groups. Their interpersonal accounts may include mentoring others, playing, and working with peers. For example, T., an African American woman, lovingly recalled her childhood in central Texas:

> I know many a day when we would walk and come back home in the neighborhood where I was. We would find many things on the porch where somebody had come by and left things for us. So as you said we were poor, but everybody in the neighborhood where I lived was poor, but we didn't know it and we were happy. Our Spanish people and our white people, we played together—the children, the Spanish parents, the white parents would come and visit in our home. We had a piano, and a lot of people would like to come into our house to play the piano and sing and gather around. So as long as we stayed in the little area where we was, it was fine, and really the difference was the school situation uptown.

3. The *sociocultural* dimension encompasses the social meanings associated with aging within a particular social context, for instance the ways in which older adults con-

trast their generation with others. The older adult narratives in this text may refer to the Great Depression or World War II as being of their generation. In this respect, narratives or personal stories give insight into an individual's life-in-context, bringing one that much closer to understanding the complexities of lives in communities during a given time (Cole & Knowles, 2001).

4. The *structural* dimension is comparable to macrosystems and includes the social policies, power relations, and economic conditions of a given society. Structural dimensions of the featured narratives include such things as how older adults obtained housing, accessed education, and used transportation.

Narratives as Clinical Practice

Narratives as Therapy

Psychotherapists such as Sigmund Freud, Alfred Adler, and Carl Jung conceptualized avenues for recalling life events, suggesting that the process had remedial effects. That is, the psychotherapeutic techniques for listening to and interpreting a patient's autobiographical memory were viewed as a means of solving problems and changing behaviors (Birren, 2001).

In 1963, Robert Butler, a pioneer in geriatric psychiatry, first called attention to reminiscence as an adaptive function for older adults; he believed it could help them find new significance and meaning in their lives. He coined the term *life review* to describe the autobiographical process of recalling past personal experiences. Borrowing from Eriksonian theory (Erikson, 1963), Butler contended that older adults used their retrospective memories, particularly potent in old age, to resolve the developmental crisis of integrity versus despair in which one achieves wisdom and peace, thereby making sense of how their lives had changed over time.

Listening to reminiscence—"the progressive return to consciousness of past experiences, particularly the resurgence of unresolved conflicts" (Butler, 1968, p. 242)—has since become an important feature of mental health treatment and empirical research. The connection between psychological well-being and positive personality reorganization continues to be studied today (Arean et al., 1993; Greene, 2002; Webster & Haight, 2002). For example, Haight, Michel, and Hendrix (2000) conducted a study of reminiscence as an intervention to relieve depression among nursing home residents. They concluded that life review is indeed an effective time-limited intervention that has lasting effects on alleviating depression.

Narratives as Reconstruction

Obtaining narratives is facilitated by people's natural tendency to tell the stories of their lives, which reveal insights about personal and social functioning across the life course. A narrative differs from a life review, during which the social worker focuses mainly on intrapsychic issues. When obtaining a narrative, the practitioner is interested in exploring the historical and cultural meaning of events. In addition, when used as a form of therapy, the narrative interview offers older adults the opportunity to rethink, reconstruct, and celebrate their stories, perhaps transcending earlier adverse events (Greene, 2007).

According to McNamee and Gergen (1992) in their book *Therapy as Social Construction*, by taking "a not knowing stance," the therapist creates a space for client dialogue and lets the client's story emerge. There are no presuppositions about the "problem" and no "universal standards" by which human development is measured. Rather, development over the life span is highly variable and embodied in the client's story (Gergen & Gergen, 1983).

The narrative perspective dissolves the dichotomy between expert social worker and non-expert client often found in the medical model. Instead of describing a person as a "problem," the professional listens to the client's story and is instructed about the client's concerns. This process is sometimes called a *dialogic approach*, in which storytellers (patients/clients) and story readers (professional providers) become conversant with each other (Clark, 2001). In this way, the client is an active participant in the helping process (White & Epston, 1990).

Anderson and Goolishian (1992) summarized eight assumptions of narrative therapy:

1. Therapeutic systems are linguistic, a product of social communication (i.e., the social worker–client conversation).
2. Therapy is based on communication as a form of action. What will the client "make" of his or her life?
3. Through the therapeutic conversation, the problem is organized and "dissolved."
4. Therapy is based on the use of language, through which one generates new meaning.
5. The role of the therapist is participant–facilitator of the therapeutic conversation.
6. The therapist uses the art of therapeutic questions.
7. Problems center around issues that diminish clients' sense of agency or personal liberation.
8. Re-storying the problem offers a new sense of agency.

Narratives in Health Care

Health and human service providers are increasingly using a narrative approach to understand the aging process and later life. For example, the field of medicine generally uses language that embodies institutional categories, a distinct nomenclature, and descriptive protocols. Diagnoses and prognoses are a necessary part of its scientific inquiry. However, obtaining medical information through the use of narrative could encourage people to express the way they make sense of their own situation.

Clark (2001) suggested that physicians use a patient-centered clinical approach to medical practice, in which patients are encouraged to give their stories in their own voices rather than conform to technical language. He went on to quote Hunter, Charon, and Coulehan (1995), who suggested that

> clinical practice is founded on the stories that patients tell their doctors and that doctors translate into cases. Helping doctors and medical students to understand these stories and to grasp their significance is an important response to patients' most damning lament about health care—that their doctors do not listen to them. (p. 791)

Clark (2001) offered another example for occupational therapists about what can be gained from listening to client narratives. He suggested that a story that focuses on past work history can answer several questions:

- What activities and roles were important to this client before his or her illness?
- What valued activities and roles can this client perform now?
- What valued activities and roles are possible in the future, given his or her residual disability?
- What valued activities and roles would the client choose as priorities for the future? (pp. 199–200)

Narrative therapy has also received increased attention in teaching hospitals, conveying fuller meaning to views of illness, treatment choices, and treatment goals (Gass, 2001). Moreover, it is increasingly used by health professionals to understand a person's past and present life (Hallberg, 2001). In short,

> whatever our professional role—counselor, chaplain, caregiver, nurse—a narrative perspective explodes our sense of the person in front of us. She is not a patient, client, or case. She is not "the gall bladder in 13A" but a person with a story as rich as our own. . . . She is not an illustration of a statistical trend, but a unique aesthetic entity, a work of art that is one-of-a-kind. . . . A narrative perspective escorts us then to the "soul" of a person. (Randall, 2001, p. 47)

Narratives as Culturally Sound Social Work Practice

Listening to and acknowledging client narratives and meaning is a vehicle for enhancing culturally based social work practice, an important professional goal (see Table 3). Narrative interviewing has also been used in social work practice (Kropf & Tandy, 1998) to challenge existing assumptions—when culture comes to life but is also rewritten or takes on new meaning (Gubrium, 1993). According to the Council on Social Work Education (2008) *Educational Policy and Accreditation Standards*, students will engage diversity and difference in practice

> and understand how diversity characterizes and shapes the human experience and is critical to the formation of identity. The dimensions of diversity are understood as the intersectionality of multiple factors including age, class, color, culture, disability, ethnicity, gender, gender identity and expression, immigration status, political ideology, race, religion, sex, and sexual orientation. Social workers appreciate that, as a consequence of difference, a person's life experiences may include oppression, poverty, marginalization, and alienation as well as privilege, power, and acclaim. (p. 5)

Finally, narrative therapies can lead to coping behaviors that can transform the person and his or her environment (Filipp, 1981):

Table 3: National Association of Social Workers
Standards for Cultural Competence in Social Work Practice

- Standard 1. Ethics and Values—Social workers shall function in accordance with the values, ethics, and standards of the profession, recognizing how personal and professional values may conflict with or accommodate the needs of diverse clients.
- Standard 2. Self-Awareness—Social workers shall seek to develop an understanding of their own personal, cultural values and beliefs as one way of appreciating the importance of multicultural identities in the lives of people.
- Standard 3. Cross-Cultural Knowledge—Social workers shall have and continue to develop specialized knowledge and understanding about the history, traditions, values, family systems, and artistic expressions of major client groups that they serve.
- Standard 4. Cross-Cultural Skills—Social workers shall use appropriate methodological approaches, skills, and techniques that reflect the workers' understanding of the role of culture in the helping process.
- Standard 5. Service Delivery—Social workers shall be knowledgeable about and skillful in the use of services available in the community and broader society and be able to make appropriate referrals for their diverse clients.
- Standard 6. Empowerment and Advocacy—Social workers shall be aware of the effect of social policies and programs on diverse client populations, advocating for and with clients whenever appropriate.
- Standard 7. Diverse Workforce—Social workers shall support and advocate for recruitment, admissions and hiring, and retention efforts in social work programs and agencies that ensure diversity within the profession.
- Standard 8. Professional Education—Social workers shall advocate for and participate in educational and training programs that help advance cultural competence within the profession.
- Standard 9. Language Diversity—Social workers shall seek to provide or advocate for the provision of information, referrals, and services in the language appropriate to the client, which may include use of interpreters.
- Standard 10. Cross-Cultural Leadership—Social workers shall be able to communicate information about diverse client groups to other professionals.

Source: National Association of Social Workers. (2001). *Standards for cultural competence in social work practice.* Washington, DC: Author.

> Assimilation [integration or transcendence] of traumatic experiences is necessary for the creation of a satisfactory life story. Without it, the story will remain incomplete, its central message vulnerable to ambiguity and fragmentation. . . . The most inspiring stories are told by those who manage to transcend early difficulties. It is never too late to restory one's life, starting from the very beginning (Coleman, 1999, p. 136).

End-of-Chapter Questions and Activities

1. Explain the history of the use of the narrative in social science.
2. Distinguish a narrative from a case study that summarizes the main elements of a client's situation.
3. Use the questionnaire developed for this study (see Table 1) and interview an older relative to learn about the discrimination he or she experienced or observed as a child. Learn about the sociohistorical context of the story. How can you use your knowledge to inform practice?

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