# Narrative Credibility to Decode Experiences in Trauma, Mental Health and Healthcare

A Concept & Theoretical Approach

# About the authors

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# Preface

Centric Community Research is about to embark on an exploration of the pressing topic of black trauma and mental health. Given the current landscape, characterized by distrust and people voicing their concerns, there has been reflection on the most appropriate ways to approach such a sensitive topic, being aware of how posing question upon question can affect individuals. We have reflected on this and determined the right methodology to access individuals who have been through trauma. Some of us have been working on serious agendas for over fifteen years, such as serious youth violence, harmful behaviors, extremism, etc., which has led us to consider hearing people's own stories of their experiences and also identifying those who are well-positioned and credible to access these narratives.

Personal stories can provide detailed insights into experiences of sickness and illness, thereby contributing to a body of knowledge that can complement clinical reports, case notes, and medical studies. In this way, healthcare practice can be both informed and illuminated by individual personal accounts.

# Introduction

In contemporary academia, post-positivist research is now perceived as more valid and legitimate (Leonard, 1997). As postmodern research methods gain wider acceptance, with provisos in some instances, personal storytelling is now considered a valid means of knowledge production (Riessman, 1990; Skeggs, 2002). Plummer (1995: 19) describes this period as the 'narrative moment'. Narratives offer ways to make sense of language, including that which is not spoken (Riessman, 1990). They also provide ways to understand interactions among individuals, groups, and societies (Plummer, 1995, and Riessman, 1993, 2002). Moreover, narratives are able to authorize the stories that ordinary people tell.

For this reason, it will be worthwhile to adopt a narrative approach when exploring experiences of trauma and illness, as part of being human involves narrating stories to ourselves and to others (Plummer, 1995).

# Stories, Narratives and Trauma

While many researchers utilise the terms 'story' and 'narrative' interchangeably, some do not and make a clear distinction (Dwyer and Emerald, 2017: 4). Stories are therefore considered to be past events for which meanings are ascribed, whereas narratives are ways in which people give meaning to their experiences.

A narrative is a story told by either an individual or a group and has a beginning, a middle, and an end. Narratives are selective accounts of past events, directed to the present listener, who can be real or imagined, making some point about the narrator (Presser, 2009: 179). Narrative enquiry includes a variety of approaches to research that emphasise "collecting, analysing and representing people's stories as told by them" (Etherington, 2004: 75).

In the 1980s, White and Epston developed Narrative Therapy and Community Work, which is a therapeutic and social practice based on post-structural and feminist thought and centres people as experts of their own lives by elevating people's own knowledge of their struggles and their resourcefulness in managing them. It encourages practitioners to always reflect on power dynamics and be aware of 'the reproduction of dominant culture in therapy' (White, 2011: 45). This is all particularly relevant when it comes to gender, race, and class. Hence, Brinkmann and Kvale (2015) suggest that, along with other aspects of an interview, interaction with others and remembering the past may be therapeutic.

Holloway and Galvin (2024: 208) in Qualitative Research in Nursing and Healthcare discuss that patients, for instance, use narratives to seek meaning and make sense of their experiences, which they want to share with significant others, while the researcher retells these stories to give them a voice and share those experiences.

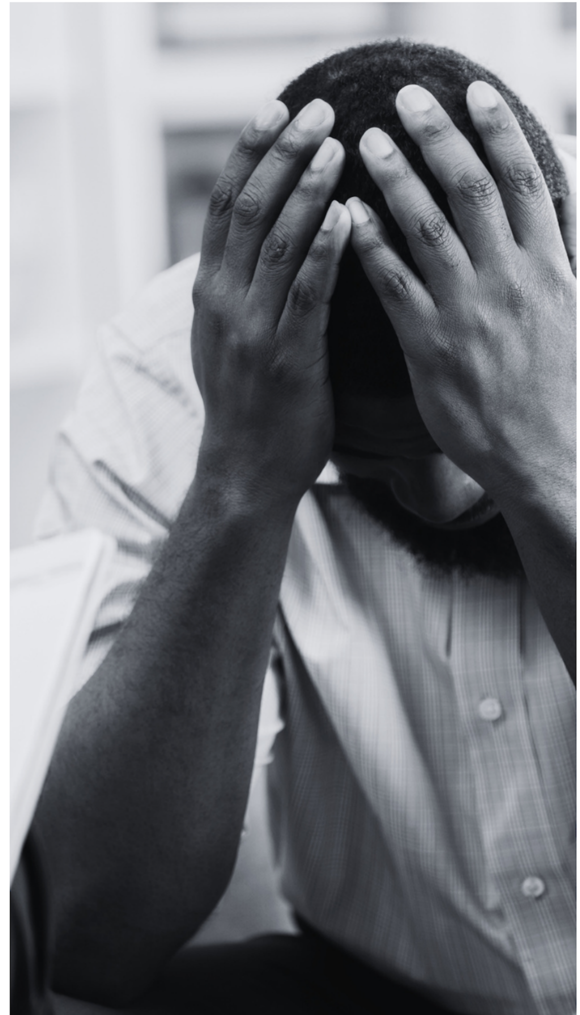
Strauven notes that one must listen for and document multi-storied accounts to avoid the reinscription of single stories which contain accounts of trauma and harms (Strauven, 2024: 135). Moreover, when working with vulnerable groups who have experienced trauma, there is an "ethical imperative to ensure the documented narratives are not retraumatizing."

The method of reading back to participants helps to centre the participants so that the method does not trump participant interests. Maintaining this helps to both prevent this method from becoming a rigid tool of methodological technocrats and jeopardising potential social change (Kuntz, 2015).

# Narratives in Illness and Health

Although narrative research is a non-traditional method in health research, it can give meaning, texture, and, importantly, humanity to what could otherwise be viewed from a distance as being a mere 'case'. Hence, Hurwitz et al. (2004: 1) argue that narrative-based approaches have developed in direct response to a dominant rationalist view of health and illness, wherein the unique personal connection as a human is often removed or sidelined. While Segal (2007: 20) posits that narrative is the "corrective to biomedical discourse, which is, conventionally at least, characterised by a thinness in descriptions of patient experience, a tendency to measurement and quantification..." In this way, narrative "restores the person ignored or cancelled out in the medical enterprise, and it places that person at the very centre" (Hunsaker-Hawkins, 1999: 12). Martin (2011: 139) notes:

> **...narrative approaches thus challenge the status and authority of the metanarratives of the modern scientific era and value 'local', experiential knowledge and individual stories alongside the 'authoritative truth' of these dominant narratives.**



# Interpreting Narratives

Paley and Eva (2005) question the notion of 'truth' as it relates to narrative, holding that 'truth' in the factual sense is irrelevant, as meaning and interpretation are what are of main significance. Mertova and Webster (2020) evoke 'verisimilitude' to denote likelihood, credibility, and plausibility. Holloway and Galvin (2024: 208) question whether the account provided by participants is indeed the authentic voice as researchers translate and interpret the narrators' accounts. Hurwitz et al. (2004) also note that narrative is important in conveying the diversity of human experience with illness. Goldie (2004: 157) posits that a narrative discourse should not aspire to be like scientific discourse in that it is distant, disconnected, and "dispassionate." Hence, an act of narration is an action, does for reasons which account for why someone relays "this particular narrative at this particular time in this particular way." For the researcher, therefore, or receiver/listener, there is a dual-interpretive task:

1. To interpret the content of what is narrated.
2. And to interpret the act of narration and the narrator's perspective on what happened ('why is he/she narrating to me this particular narrative, in this way at this time?').

In realising this dual interpretive task, both the narrator and the listener can be empowered, as the narrators will have confidence that the listener will be able to understand their reasons for narrating this particular narrative, at this particular time in this particular way (Goldie, 2004: 157). While the listener/researcher will be someone who has built the rapport to whom the narrator can comfortably narrate.

Narrative research, when utilised well, can support interdisciplinary work in health studies. Nevertheless, it is important to note that when listening to stories, one must be aware that in some cultures or contexts, stories may be regarded as good stories if they are embellished (Winter et al., 2016). Further to this, there can also be bias on the part of researchers who may tend to focus on negative emotions, such as sadness, fear, shame, or anger, rather than on positive feelings of joy and happiness (Prior, 2016: 185). To the extent that positive experiences of joy and happiness may be regarded as mere coping mechanisms while the negative are seen as the authentic default setting. Prior (2016: 192) posits that there are often cultural factors that promote talk of negative emotions and feelings over positive ones, and that in the Western context, children may be socialised to do this.

# Stories and Emotions

However, Prior (2016: 187) suggests that "moral breaches and transgressive events in human social life" may precisely and naturally result in the production of talk that highlights negative emotions. These story-fragments are described as 'proto-stories' by Gabriel (2000: 26), which then become resources for further sharing and development. Hence, Zech et al. (2004: 180) emphasise that the storyteller decides with whom to share a story based on the warmth and emotional support that can be provided to the sharer. They state:

**"[S]ocial sharing may well provide help in meeting two fundamental human needs: affiliation and social consensus. We have shown that agreement as well as empathy with the listener led to more affective closeness, to a partial restoration of a belief in a just world, and to a decrease of loneliness."**

In this vein, Prior (2016: 191) highlights that:

**"Story recipients play a key role in the interactional construction of stories, and there is ample evidence to demonstrate that recipients and their responses influence the perceived and real-world benefits for the tellers who story their emotional and traumatic experiences."**

Prior continues and discusses, therefore, that in both longitudinal and ethnographic interviews:

**"The increased comfort of the interviewees with the interviewer over time may explain the escalating emotionality of the narratives that they collaboratively produce."**

In narrative research and analysis, it is imperative to "identify the positions from which storytellers construct their stories as these positions" are vital in understanding how different parts are neatly woven together "in response to the available cultural resources and interpersonal interactions" (Esin, 2011: 96). Prior (2016: 214) mentions that:

**"Researchers have long observed that our participants produce highly emotional and detailed accounts to explain the personal histories and responses to them that have shaped their present-day realities. We have given much attention to the various topics and concerns that research participants raise and how they weave language and identity together in the 'there-and-then' storyworld as well as in the 'here-and-now' of the telling. We are also becoming increasingly aware that research participants, too, recognise that they are not just reporting events and perceptions but are in the moment generating and managing versions as well as the emotionality of their personal histories for the researcher, themselves and the larger research project."**

# Narratives and Objectivity

Although the narration may be true in meaning, it may not always be based on fact or objective reality; it may be a social construction and perception of what has happened to the narrator (Holloway and Galvin, 2024: 208). It is important for the researcher to be reflexive in this epistemic enterprise, as the knowledge generated in social research can never be entirely objective. Hence, it is vital for the researcher to acknowledge their own positionality, biases, and awareness of how their "presence contributes to and affects the construction of knowledge" (Dwyer and Emerald, 2017: 5). Nevertheless, Goldie suggests (2004: 157) that a narrative can indeed be objective in that the narrator's perspective can be appropriate in that it involves "an appropriate evaluation of, and emotional response to, what is related."

Holloway and Galvin (2024: 208) suggest that when people have experienced trauma, illness, or a relationship break-up, these are particular moments wherein people feel powerless to effect change. Individuals experiencing illness and suffering may have an impaired sense of self; these moments will, therefore, be explained in a manner different from those with power. Holloway and Galvin (2024: 208) therefore hold that illness narratives differ from other stories as they have an 'altered temporality'. In other stories, "the present connects effortlessly to the past and future."

While Strauven (2024: 126) notes the importance of documenting participants' contributions and rendering visible and honouring their understandings and knowledge in their own right. In this way, the researcher assumes a 'witness' perspective and elicits resonance, which describes the retellings in narrative practice that resonate strongly with what people give value to in life and also characterise the personal experiences of a witness when a story resonates with them (White, 2007). Strauven (2024: 127) notes:

> **"The experience of resonance, felt by both the participant and the researcher-witness, often engenders a moment of pause and a personal reflection of why or how something is reverberating. It often evokes new perspectives on an issue or enlivens particular understandings of life."**

# Positionality and Those Well-Placed to Explore Narratives

A researcher having the requisite experiential knowledge and familiarity with those who are participating in the research goes a long way in facilitating rapport and accessing stories and narratives that would otherwise be below the radar. Community researchers equipped with direct involvement in mental health, whether personally, due to family and friends, or professionally, are well-placed to gain what Jupp calls 'narrative credibility' (Jupp, 2013: 10). Distant, detached, clinical, and colonial approaches to research within communities are, therefore, unable to access such authentic narratives and stories. Jupp (2013) discusses, in the context of teacher story research, that although conventional research prides itself on being distant, life history, and teacher story research valorise the researcher's involvement, commitments to schools and children, and lived experiences as being essential for the research. Personal life stories furnish a researcher with the appropriate credentials that warrant narrative credibility. As Massoud (2022) states:

> **"Situating personal experience in relation to empirical research may increase the writer's authority on the topic and help readers to connect with the work at multiple levels: intellectually, professionally, and personally.**

Life stories are particularly significant for narratives of trauma, and in interviews, a person may relay such traumata differently from the rest of the story (Benezer, 1999: 34). Rogobete (2015: 89) also suggests that when exploring traumatic experiences of those who lived through apartheid in South Africa, narratives of serious trauma are not prototypical narrative forms. This is because when traumatic experiences are brought to memory, it is often accompanied by confusion, ambiguity, and disorientation. As a result, participants may not follow a chronological order when recounting events and may move back and forth through time. Narrative plots, therefore, may take sudden turns, including tragic events or emotional situations, although trauma survivors may begin their narratives by recalling the traumatic event.

## Positionality and Those Well-Placed to Explore Narratives

In this regard, there are some signals of traumata that can help to identify traumatic experiences within narratives. Benezer (1999: 34-35) posits that these include: **the inability to tell the story,** which may require the interviewer to circumvent the contents of the trauma; cognitive emotional disorientation, wherein the narrator may get irate with the interviewer and lose the sense of where they are or cannot express themselves; **intrusive images** of a traumatic event that may appear as a flash to the narrator and disrupt the flow of the narrative; **losing oneself in the traumatic event**, such that there may be a period of extended silence, and the interviewer may need to intervene, as the person has lost themselves in recounting the traumatic event; **repetition** of an event and recounting it in specific detail in a manner that indicates that the narrator has not yet come to terms with the event (in such cases, the interviewer may need to signpost the person to services for further support); **emotional numbness**, such that horrific events are mentioned and appear to have no impact whatsoever on the individual or indicate a forced detachment from the event and a removal of it from the person's emotions; **loss of emotional control** resulting in anger, fear, or tears; **periods of long silence** when recounting an event, which may indicate that the event was particularly tormenting or painful for the individual.

# Conclusion

Narrative work is often transactional and hence is focused on the way in which knowledge is constructed within social settings, whether via the interactions between the researcher and participant/s and/or between participants and others. The way findings are developed, and how the relationships are built, influences the epistemological approach (Dwyer and Emerald, 2017: 5).

Narrative research, therefore, does not merely relay people's stories as it also involves an exploration of socio-cultural, contextual, linguistic, and institutional narratives in which experiences are shaped and relayed. Narrative methods of inquiry may allow for new ways to enhance and transform experiences for participants and others, particularly, as noted by Tseris (2019) in "Trauma, Women's Mental Health and Social Justice," as it is able to disrupt oppressive dominant discourses when power operations are named, and hegemonic controls resisted.

Narrative research can analyze the emotional aspects of inequality and disadvantage, and hence when narratives are developed within therapeutic contexts, there is a huge capacity to not only demand justice but also reject inequity.

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