

## RESEARCH ARTICLE

# Life story research: A relevant methodology for counsellors and psychotherapists

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### Abstract

**Aims:** This paper introduces, describes and proposes life story research as an important, relevant and appropriate contribution to counselling and psychotherapy research. It shows how narrative knowledge is created and constructed through the stories people tell about their lived experiences and explores the concept of 'narrative knowing' (Bruner, 1986). **Methods:** Drawing on life story research with people who linked their history of problematic drug use with experiences of historic trauma/abuse, the paper contributes to the ongoing discussion related to the similarities/differences between therapy and research and what we might learn from each that informs the other. **Implications for practice:** The paper offers narrative ideas and practices as ways of researching matters of social and psychological importance. It suggests that therapists (and counselling researchers) could learn from what participants tell us about the therapeutic value of using life story methods which one participant described as helping him to face 'out into the world, without unduly or specifically delving into, or focusing on [my] emotional state'. This learning may be particularly relevant for therapists working with traumatised clients.

**Keywords:** *Life story research, narrative inquiry, practitioner research, therapeutic research*

### Introduction

Many counsellors and psychotherapists view research as an endeavour that is conducted in the ivory towers of academia and 'not for the likes of us' (Bridges, 2007). So this paper offers the view that life story research – a version of narrative inquiry – is a relevant and appropriate methodology for practitioners in the field. It also invites the reader to glimpse two participants' explorations of the therapeutic impact of being involved in this kind of research, and their understandings of how that was similar and different to their experiences of therapy.

### Life story research

Life story research methodologies (Etherington, 2007a; Holstein & Gubrium, 1999; Josselson & Lieblich, 1999; Lieblich et al., 1998; Mishler, 1999; Ochberg, 1994; Roberts, 2002) tend to focus on peoples' stories of particular aspects of lived experience (e.g. bereavement, infertility, abuse, drug misuse) against the backdrop of a whole life.

This approach draws on what Bruner described as 'narrative knowledge' (Bruner, 1986), which is created and co-constructed through the stories people tell about their lived experiences, and the meanings they give to those experiences over time that might change and develop as their stories unfold. This kind of

knowledge construction invites us to pay attention to the details of local stories and the contexts in which they are embedded.

The value of enabling people to create and tell stories that help them make meaning of their experiences has long been understood in therapeutic circles, and more recently, in response to trauma research, this interest has proliferated to other fields, such as medicine (Harber & Pennebaker, 1992; Pennebaker, 1993). It follows then, that narratives, or life stories, are particularly relevant means of knowledge creation appropriate for counsellors and psychotherapists.

Knowledge embedded in life stories is memorable, interesting and sometimes transforming. Life stories allow us to bring together many layers of understandings about a person, about their culture, and about how they have created change in their lives: we hear people struggle to make sense of the past and create meanings as they tell and/or 'show' us what happened to them. The shape and form of a story helps the teller (and the listener) to organise information about the storyteller's personal and social lives; how they have interpreted past events; the values, beliefs and experiences that guide those interpretations; and their hopes, intentions and plans for the future. As researchers try to analyse or re-tell those stories we find complex multi-layered patterns, descriptions of identity construction and reconstruction, and evidence

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of social discourses that impact on a person's knowledge creation from specific cultural standpoints (Daiute & Lightfoot, 2004; Etherington, 2007a; Harber & Pennebaker, 1992). Knowledge gained in this way 'is situated, transient, partial and provisional; characterized by multiple voices, perspectives, truths and meanings.' (McCormack, 2004, p. 220)

Life stories also have meaning beyond the local and personal context; they resonate with others and outlast their telling or reading: they sometimes have profound consequences. They change us in ways we may not always anticipate because they can move us emotionally, change public and political attitudes and opinions, and sometimes influence future actions.<sup>1</sup>

It has been well recognised that telling life stories can also have a 'recuperative role' (Frank, 2000; Rosenthal, 2003), for individuals, relationships and societies and therefore becomes a moral act (Frank, 1995).

### Therapeutic impact of life story research

With this in mind I move on here to show what two research participants told me about the therapeutic impact of their involvement in a study I conducted entitled 'Trauma, drug misuse and transforming identities: a life story approach' (Etherington, 2007a), for which I invited life stories from eight people who understood there to be links between their childhood experiences of trauma and their subsequent drug misuse. Rather than focusing exclusively on stories of drug misuse *per se*, the study explored the individual's understanding of their drug misuse and subsequent recovery within the context of their life stories, their social environments and the wider social/cultural resources they relied on to help them make sense and meaning of their lives.

The limitations on word count for this paper does not allow for me to describe fully the methodological and ethical implications of this study, but these can be found in detail elsewhere (Etherington, 2007a). However, it was ethically important for me to choose participants who had enough reflective grasp upon their life experiences to ensure that they would not be re-traumatised by re-telling their stories for the research. The quality and ongoing nature of my relationships with participants was also crucial to their wellbeing and interests. In line with feminist values, my relationships with the people who told their stories for this study included an examination of power issues with a view to greater equality (Etherington, 2007b), and a commitment to providing a platform from which the voices of this previously marginalised group could be heard. This required me to work towards developing trust and openness in the relationships through high levels of ethical and critical engagement; by showing transparently my own part in the knowledge construction through the use of reflexivity; mutual and sincere collaboration, over time (a reciprocal process whereby each party educates the other); and the storyteller having full voice, whilst

including my own voice. It also meant sharing ownership of data with participants (until an agreed point when it would be submitted for publication), thereby opening up to investigation the assumptions that professionals are the 'experts'.

During conversations with life storytellers who had previously been in therapeutic relationships of different kinds and in different contexts, sometimes over several years, I was surprised to hear the degree to which they had made important and therapeutic shifts in their self understanding as a result of telling their life stories for this research and I became curious about *how* that had happened and how that had been similar/different from their experiences of therapy.

I was already aware of literature concerning the therapeutic impact of qualitative research for participants (notably Etherington, 1996, 2001; Hart & Crawford-Wright, 1999; Rennie, 1994; Rosenthal, 2003; Wosket, 1999), and that, in some cases, participants reported finding research conversations *more* therapeutic than the therapy itself (Gale, 1992). I was also aware that what my participants were telling me seemed in some ways different from what had previously been found. So I wanted to examine this more closely and try to fully grasp *in what ways* life story research, in particular, is experienced as therapeutic, and how it compared with participants' experiences of therapy.

In order to contextualise their feedback on the therapeutic impact of their involvement I will represent below extracts of Omar and George's (pseudonyms) life stories which can be read in full in Etherington (2007a). There were several more examples of this phenomenon among other participants, but I have limited myself to only two examples to meet the word restrictions of this paper. Both of these examples focus on how Omar and George re-storied and redefined their traumatic experiences during childhood as they told their life stories for research.

### Omar's story

Omar was 32 and studying counselling psychology when we met. He was keen to be involved in the study, firstly because he was interested in the links between early trauma and subsequent drug misuse both personally and professionally; and secondly, having been trained in quantitative and traditional research methods, he was curious about how I would use life stories for research.

Omar had been born in Pakistan in 1973 and came with his parents and three older siblings to live in England when he was three years old; two further siblings were born in the UK. They lived in an 'all white' area on the south coast of England where they 'stuck out like a sore thumb'. Their father was an extremely hard-working man who was rarely at home. Although they were a Muslim family, the children attended a Catholic primary school that had a reputation for providing a 'good education' and a

'strict' regime, in line with his parents' values. He enjoyed his primary school years which he described as his 'heydays'.

He identified his 'trauma' as being related to being at secondary school where he was bullied, called 'dirty Paki' and similar racist names, and he was particularly 'embarrassed' about having a different skin colour and religion from others in his school. Between the ages of 15–24 Omar used alcohol, cannabis, crack cocaine, ecstasy, LSD, benzodiazepines, and heroin. At the time we met he had been abstinent from all substances for eight years. After several years of homelessness whilst addicted to substances he eventually received help through a residential rehabilitation programme and, in later years, by forming a connection with Alcoholics Anonymous (AA) while travelling in the US. He was currently in therapy and being supported by an AA mentor.

Omar told me during the early part of our conversation about his happy memories of his primary school years, but as the conversation progressed a very different picture emerged:

I can remember being really, really anxious as a child, and I always used to think 'there's something wrong with me'. I used to get my mum to take me to the hospital and the doctor used to say it was anxiety.

I used to be really, really, scared. I have memories of having nightmares and being really, really, anxious ...

As he spoke about his extreme anxiety as a child I wondered what it was about his 'heydays' during primary school years that had caused him to be so anxious. It was clear that racial abuse in the secondary school created anxiety, but here he was talking about a much earlier stage in his life.

Trying to contextualise his experiences of anxiety I asked if anxiety was located inside the family or out in the world. He responded that he experienced anxiety both inside the family *and* outside in the world. He then mentioned that as he was speaking he was having memories about his life and finding it difficult to keep on a 'constant track'. He began to sound slightly confused and I noticed that his language had begun to move in and out of the present tense. I was concerned that talking about his childhood may have been triggering him back into unprocessed trauma.

I suggested that we could stop or take a break, but he wanted to continue so I asked him if he could say more about thinking there was something wrong with him.

Yes, I have a memory of my mum taking me to the general hospital for an appointment and they'd given me the all clear. They took some blood tests and I remember coming out crying, because I knew there must be something wrong with me.

He then moved on to speak again about being 14 years old and becoming quite violent, identifying himself as a 'troublemaker'. He began to describe how he moved from using alcohol and cannabis to using heroin when he was 18 years old, and becoming a dealer. I asked how his very religious parents dealt with his drug using and dealing, and suddenly he began to talk about his early years again:

I remember my parents being disappointed and I remember kind of ... I'm not ...

My dad was quite violent when we were younger, really violent to me, but a lot more to my older brothers. He just used to pick up anything and whack you with it. I mean literally anything, like cricket bat, anything, because he just had this temper, which was-really scary.

I was very surprised by this sudden revelation. We had been talking for over an hour on the links between childhood trauma and subsequent drug misuse and this was the first time Omar had mentioned his father's violence. I pointed this out to him:

I know. I know, I know. Yes I just...I mean really we were all very scared. He was a big man.

I asked if he thought this might explain the anxiety. Was he frightened of his father?

Don't know if that was to do with it, still can't ... I was ... I was scared of his temper. I was scared of my mum as well ... she...was violent, not as violent as my dad ... There was a lot going on. My sister taking her overdoses ...

... And back then, he [Dad] was a big guy, really healthy, and he just used to lash out. We didn't see a lot of him, but when we did, the discipline – he would lose it – because he used to hit mum as well. And those kind of arguments ... I've forgotten about all that ... these arguments with my mum and dad – and trying to separate them ... , trying to protect my mum from my dad. All of us used to try and do that. He just used to have this fuse, just go ballistic. You would be in fear of your life actually – my mum as well. But my mum's violence wasn't on his level, but we were scared of my mum, she used to hit us as well ...

I felt myself shiver at the words 'in fear of your life', imagining what it might have been like for those children, and his mother, and I was making theoretical sense of his dreadful anxiety as a child: and understanding the additional distress of being told by the doctor that there was nothing wrong. In his own way he had been trying to tell people there was something *really* wrong – but without a frame of reference through which to understand his experiences, or language with which to communicate what

was wrong, he was left to deal with anxiety on his own.

### *Second meeting*

It had taken almost six weeks for us to arrange our second meeting. In the meantime I had sent Omar the transcript of our first meeting and suggested that we both read it prior to meeting again. When we met I inquired how he had been feeling about our previous conversation and he answered:

Omar: Actually since the last time we met ... I've been talking to my therapist about my anxiety as a child. Now it fits into place with my dad's violent behaviour, and I had never made the connection before. It's really odd – I've never looked at it that way.

Kim: So you hadn't made that connection in previous therapy?

Omar: No, no ...

Kim: It seemed to come up quite late in the conversation didn't it? I was quite surprised.

Omar: Yes, it's almost like I'd blocked it out really. It's like it's there, but isn't there – but now it's very visible to me that that was going on and it was very scary for me as a child.

I was curious about how our conversation had helped him to make those connections when therapy had not. So I asked him how he saw the differences and/or similarities between our research conversations and his therapy/counselling.

Omar: Yes, I don't see it as counselling. It has its similarities, but no, I think it's really me restructuring or mapping, it's almost like mapping my whole life, and ... yes, putting it together, because it is pretty much all over the place. And I don't think in therapy you get that opportunity – well I haven't really – unless you're given some sort of homework or a timeline or something ...

Kim: So the telling of the story meant that you needed to order it? And I've helped you with that a bit in saying, 'What happened then', or, 'How old were you when that happened?' That's kind of kept you a bit on track?

Omar: Yes definitely ... it's almost like a jigsaw puzzle, like missing pieces making more connections. It's been a very useful experience. I keep thinking about emailing it [transcript] to my sponsor, just so he can get a real good insight into what's been going on. Like I say, I keep keying in on that part about the connection with the anxiety as a child – that has baffled me for years ... and it sounds so simple after hearing what was going on

in my life with the violence. It was just like, 'of course – that was what was going on in my life!' I feel relieved. ... it's funny really, it's brought up a lot for me, yes. It's therapy but it's not therapy.

Kim: It's therapeutic, but it's not therapy? But there's also something different in the relationship isn't there? ... In the research relationship I think it's easier to meet as kind of collaborators, colleagues, equals: I need something from you and you're helping me out here, whereas in therapy you come as the one who needs help. I think that has an impact on the power relationships.

Omar: Yes, absolutely, that's a really good point ... yes, the dynamics are completely different. I mean when I'm talking to my therapist it's very different ...

Kim: In what way?

Omar: I think I feel a bit more pressured when I'm in therapy. I feel a bit more relaxed here, in expressing my story. In the therapeutic relationship it's very much more ... I don't know, not much to say, it's more fearful, I'm scared I'm going to be analysed about something. I'm watching for it really ... Yes, I do hold back with him, and I don't know – is that because he's a man or we haven't built up a complete trust? Last week he made a comment to me: he said, maybe you want to start trusting me sooner or later? So he's very aware of it as well.

Kim: Yes, I was really interested that you said you might send it [the transcript] to your mentor but you didn't say you might send it to your therapist.

Omar: No. [laughter]

Kim: So you're not worried about me analysing this data as a researcher?

Omar: I'm not worried, I'm curious about it how you're going to do it.

### *What Omar's story shows*

*The value of 'restructuring' or 'mapping' his life story:* this allows him to make connections between aspects of his life that were previously disconnected; fitting pieces of the jigsaw puzzle together rather than having them 'all over the place' he is then able to see events in his life as part of a bigger picture and how the different parts relate to one another, a cultural and social picture, rather than separated pieces related only to his personal psychology or 'pathology' or only his drug misuse. From this position he could step outside his individual, 'psychological' or 'addiction' story and see things he could not see before. He began to see that fear and anxiety was constituted by events and

relationships in his environment, rather than being caused by having something wrong with him.

Omar seems to be describing *an active* process of restructuring and mapping as holding value for him: Pennebaker (1993), suggests that it is this 'movement toward [my emphasis] the development of a narrative', i.e. the process, rather than the endpoint of *having* a constructed life story *per se*, that holds therapeutic value for the storyteller, (p. 546). Life story research provides participants with opportunities to move towards developing a narrative of their lives, in ways that contextualises the life within its cultural context.

*The relationship dynamics are completely different:* although Omar realised he might feel more relaxed as a research participant because I am female (bearing mind his therapist is the same gender as his very violent father), he agreed that the dynamic in our relationship is quite different from that with his therapist. Ours is a different kind of relationship, a research relationship that is more akin to 'a working alliance' – an adult-to-adult relationship that focuses on the here-and-now, even whilst the participant revisits childhood memories and stories. Being in a traditional therapeutic relationship may evoke memories of parent-child relationships, which can sometimes be experienced as nurturing and/or reparative, but may sometimes evoke childlike feelings of powerlessness or fear.

My approach to life story research is strongly influenced by feminist principles related to power and equality and this requires me to be collaborative, transparent and reflexive in my research relationships: reflexivity being at the heart of feminist methodologies and increasingly other methodologies too (Etherington, 2004). 'It permeates every aspect of the research process, challenging us to be more fully conscious of the ideology, culture, and politics of those we study and those we select as our audience', (Hertz, 1997, p. viii). This kind of respectful, trusting, collaborative working relationship remains the cornerstone of transformation where human connection is restored and agency remains central to the process.

*Fear of being analysed:* Omar seemed more relaxed, not only about telling his stories, but also about my analysis of them. In our early conversations I had pointed out that if I felt the need to make interpretations I would make transparent the values, beliefs and ideas that lay behind them and that we would be co-constructing interpretations rather than me adopting the 'expert' position of knowing more than him about his life. He had also read some of my previous work where he could see how I had transparently reported those ways of working (Etherington, 2000, 2004).

### George's story

George was 50 when we met. He was a musician and a counsellor working in a prison. He was a third son, born in 1954. He had started using drugs at the age of 17 and carried on doing so for at least 10 years.

The use of drugs was very much part of the music scene and meant 'smoking dope, pot, cannabis, more or less every day and doing other drugs depending on the situation: LSD, cocaine'.

From around the age of five he had known things were not right in his family: 'my childhood seemed to have no form'. He 'despised' his father who was violent towards his older brother, but he was close to his mother.

I was born with a very bad skin disease: she had to bathe me in olive oil three times a day, and she told me afterwards that this just bonded her to me and she grew to love me intensely.

What happened was that my mother left, just disappeared, and I was left with them, and I was distraught. She was the only bit of sanity I had in my life and she just disappeared.

And I was left there with my father and my brothers, and it was horrible, just horrible. And there were a couple of things that happened with my brother that were very difficult for me, there was mild sexual abuse and ...

I noticed how the language he used – 'there was mild sexual abuse' rather than saying what I thought he meant ('I was sexually abused') depersonalised his experience. So I asked for clarification: 'Did he abuse you?'

He abused me, yes, and there was one time when he was suffocating me with a pillow that was quite traumatic for me.

He mentioned then that the abuse was 'mild' and although I did not pursue this story (although in my role as a therapist I might have done so), George returned to those events later in our conversation, referring this time to the sexual abuse as a 'homosexual experience.' I enquired how he came to define this as a 'homosexual' experience – realising that in the era in which he had experienced those events neither he nor society may have had any other frame of reference for understanding male on male sexual abuse. This had me wondering about the impact of that thinking on his sense of self and identity and on his ability to disclose such activities at a time when homosexuality might have been, at best, unfortunate and, at worst, illegal (Etherington, 2000).

At this point George seemed to want to 'thicken' (Geertz, 1973) his story of sexual abuse and, as he had already mentioned masturbation, I was assuming this was what he had referred to as 'mild' abuse. So I asked him if this was the case. He told me that his abuse had involved oral sex as well as masturbation. I observed: 'You said it was mild?' – trying to understand how his beliefs had informed this definition:

Well, yes, well, exactly. I mean I know. You see, here I'm being defensive and I'm minimising what happened to me, and I don't need to do that.

By noticing the language he was using to define his experience, a space was opened up where George could re-examine this description and therefore re-evaluate the meanings he might attach to those events. I offered him my understanding of the word 'mild' in this context when I said: 'I had imagined there'd been a bit of showing and a bit of touching', engaging with him in a reflexive cycle of meaning-making that shifts back and forth between the cultural and the personal for both of us. From my own previous work I was aware of the difficulty for many people in defining male abuse when socialisation messages lead males to believe that anything sexual is OK for 'normal' males. George responded by explaining how he had redefined those experiences several times already, depending on the context in which he found himself.

Well, I began to realise that it was sexual abuse six years ago when I joined an organisation that works with sexually abused people, and started reading stuff, and listening to other men's stories of abuse. I said to someone, I was sexually abused by my brother when I was seven or eight. And he said, 'Whoa, are you all right?'

I went into therapy and started looking at this and I realised I had been sexually abused.

I asked George how he had made sense of what was happening at the time and he replied:

I thought it was normal, you know, this is what brothers do ... when you're investigating sexuality ... that's what you might do.

Later, he told me that working in the context of the prison, and reading and learning more about the sexual abuse of males, helped him to see that 'it was the power imbalance' between an 8 year old and his 13-year-old brother 'that makes it abuse, and yes ... it was mild in comparison to what happens to some other people, but that's not the point.'

So the context had helped him to redefine his experience as 'abuse', whilst at the same time comparing his own experiences with those of his clients, he had held onto his view of it as 'mild'.

After our conversation George emailed me saying:

Just wanted to tell you how energised and positive I felt after our meeting on Wednesday. I very much enjoyed talking about myself for 2 hours (!) and heard myself saying things and expressing them in a way I had not noticed before. Each time I reflect on the narrative of my life, it subtly changes.

I was intrigued to know more of how George understood his positive feelings after our meeting and in further email conversations he told me:

Each time I tell my story my narrative develops and allows me to see it differently. This certainly happened for me on this occasion. The context of research, rather than personal therapy, somehow faced me out into the world rather than inwardly toward myself, thereby altering the dynamic of the experience. There were similarities to therapy in that I felt you were genuinely present, as well as being sensitive to my story and my feelings, but you remained focused on the specifics of the task at hand, which were to facilitate the description of my experience and my thoughts on the development of my coping mechanisms without unduly or specifically delving into, or focusing on, my emotional state.

There was also the simple therapeutic effect of talking about myself to someone who seemed genuinely interested in what I had to say – I am of consequence and my experience has some importance – so much so that someone may even put it into a book! This also ties into the idea of the Wounded Healer, in that the negative aspects of my trauma may be turned to some positive use and may even help somebody else.

I had an awareness that I was taking part in a project with other people and was therefore one of a community of participants seeking to explore a subject that holds meaning for me.

I fully accepted for the first time that I had been sexually abused in my childhood. I *realised* it. I find it difficult to explain why this should be. I think it may be to do with the 'facing out into the world' that I mentioned above. I described the experience to my wife as, 'Something moved, something changed'. I had always been aware of the events of my childhood, but had always tended to minimise the effect that they had had on me. It was as if, suddenly, the rational and intellectual met with the emotional. As if my Child finally understood what my Adult and Parent had been saying for some time.

#### *What George's story shows*

*The value of re-telling his story:* stories depend on who they are being told to and why they are being told, so the possibility of something new is created each time they are told. The process of participating in life story research allows people to stand back from their lives and use narrative structures as an opportunity to 'render meaningful that which previously wasn't, and to re-conceive of that which has already been rendered meaningful' (White, 2001, p. 23).

*Facing out into the world:* My understanding of what George meant by this is informed by narrative ideas that suggest that by helping him to reconstruct his life story within a discursive conversation that highlighted how his experiencing and understanding of his life events may have been shaped by social discourses available to him at the time, he was able to shift from seeing his experiences as related only to his personal, internal, experiential state towards viewing them as shaped within certain contexts, relationships and discourses of power, thereby allowing him to feel that 'something moved, something changed'. The focus on context rather than internal experiential states could also reduce the risk of re-traumatising clients.

*Being part of a community of participants:* Trauma creates a sense of isolation and alienation both within survivors who may separate out aspects of their traumatic experiences in order to survive them, and without, as they withdraw from others to keep themselves safe from external threat. Inviting participants to become part of a community of people with similar stories can break down that sense of isolation and stigma. Therapy usually takes place in a one-to-one relationship between therapist and client, thus maybe re-inforcing that sense of separation. Laurel Richardson (2000, p. 26), reminds us that contexts for sharing stories does not need to be limited to face-to-face meetings: 'By emotionally binding together people who have had the same experiences, whether in touch with each other or not, the collective story overcomes some of the isolation and alienation of contemporary life. It provides a sociological community, the linking of separate individuals into a shared consciousness'. Although research participants may never meet each other face-to-face, they can nevertheless feel part of a shared community.

*Being of importance:* People who have suffered in silence, and had that suffering ignored or denied, can come to believe that they do not matter. This sense of importance can begin from the point where potential participants read an advertisement for participants whose stories match their own. In response to my advertisement several people telephoned to say how pleased and relieved they were to see a researcher focusing on the potential links between childhood trauma and drug misuse. They also told me that nobody in drug treatment or therapy had ever invited them to tell their stories of drug misuse from the perspective of childhood trauma, so they had never articulated those connections, even whilst knowing they were there.

Through being listened to respectfully and carefully by a researcher who is interested in their stories and in how they make sense of their experiences, they learn that their life stories *are* of value to others: when listeners and readers are moved by those stories, their suffering is affirmed.

*Turning negative experiences to positive use:* Although an important part of my research involved

examining parts of a drug-using lifestyle for its negative consequences it was also important to examine my participants' life stories for what positively helped them build a more rewarding sense of self and identity. Resilient trauma survivors often use their own experiences to reach out to help others. By helping others they help themselves maintain a continuous sense of self-transformation; they give of themselves in nurturing ways without expectations of immediate benefits (Wilson, 2006, p. 379).

George had told me that viewing himself as a wounded healer helped him make sense of his life:

...I've lived an interesting creative life, yes, ... I wouldn't be sat here talking to you if I hadn't done everything that I've done so, you know, I don't regret it, but when I'm at the point of attempting to make sense of it ... I am the wounded healer in a *specific* way ... *that* is now making sense of my life. I can take that wound and use it to help other people heal themselves, and that is the focus of the rest of my life .... It makes complete meaning out of the first bit and now ... well it's not to dissipate the rest of my life, it's to focus it and use it.

## Discussion

George and Omar are clear about how their involvement in research has been different from their experience of therapy, whilst experiencing both as therapeutic. As a therapist who is also researcher I also recognize the differences between both activities, whilst recognizing the similarities and enjoying the fluidity possible between them. First and foremost, the *purpose* is different and because the purpose is different other things are different too. First, we are working towards satisfying *my* agenda as the researcher, whilst acknowledging that people who offer their stories usually choose to do so for their own reasons, so at best the benefits are two-way.

Second, the boundaries of confidentiality are different, in that these stories will *not* remain private within the confines of the therapy room but open and accessible to interested others through publications and conference presentations. Third, as researchers we not only bear witness to a person's life, as we do in therapy, but we also give public testimony to what we have witnessed. Fourth, the relationships are usually different: in therapy: most therapeutic relationships are sustained over time, and underpinned by the view that 'the relationship' is central to the process, whereas in life story research, whilst collaborative and reflexive relationships are valued, the stories are central.

However, as shown by Omar and George above, there are many similarities between both activities. This theme is further explored in Martin (2008). Most qualitative research relies upon interviews and

research conversations, much like the conversational interactions that take place between clients and therapists, especially within collaborative, feminist and narrative approaches to therapy (Anderson & Gehart, 2007). Indeed, narrative therapists describe the work they do as co-research which 'lends itself to a blurring of research and therapy practices' (Speedy, 2008, p. 11).

This paper supports what others have said about how people make meaning of their lives by reflexively ordering them as life stories (Bruner, 1990; Giddens, 1991; Hanninen & Koski-Jannes, 1999; Polkinghorne, 1988). Events from the past take on extraordinary meaning over time as their significance in the overall story of our lives and times is realised, depending on the stocks of knowledge we have available to us at any one time, and this changes as we mature and learn.

Storytelling is a social activity that requires an audience, whether that is a therapist, researcher, friend or other interested persons. When we tell our life stories as adults we do so from a wider perspective, being able to place our childhood experiences in the larger context of adolescent and adult experience. When our interpretations of our lives and experiences have been shaped by cultural conditioning, with maturity we are able to stand back from that culture and examine its influence. When the discourses available are examined and expanded, or recognised for simply being one among many different ways of understanding and explaining people and their lives, this allows us to describe, explain or interpret events in different ways and therefore alter our responses, (Gergen, 1999, p. 115). This creates possibilities for people to engage with alternative identity projects that provide opportunities for 'creative reengagements with their own histories' (White, 2001, p. 66) providing cause for hope and an antidote to despair (White, 2001, p. 67).

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### Biographical note

**Kim Etherington** is a Professor of Narrative and Life Story Research at the University of Bristol, UK, Fellow of BACP, and BACP senior accredited counsellor and supervisor. Kim teaches and supervises masters and doctoral students. She has published seven books and many journal articles based on research ideas drawn from her teaching and her practice as a counsellor, supervisor, consultant and trainer in voluntary and statutory organisations.

### Note

1. Based upon the life stories of two individuals, researched and written by Jeremy Sandford, his drama documentaries *Cathy Come Home* (BBC, 1966), and *Edna, the Inebriate Woman* (BBC, 1971) led to questions in Parliament about the plight of the homeless, poor and dispossessed.

*Cathy Come Home* was watched by 12 million people when it was first broadcast (and has been shown again more recently). It broached issues that were not then widely discussed in the popular media, such as homelessness, unemployment, and the rights of mothers to keep their children. These dramas could be viewed as performative life story research. Was it entirely coincidental that the charity Shelter was launched soon after the film was first broadcast?

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