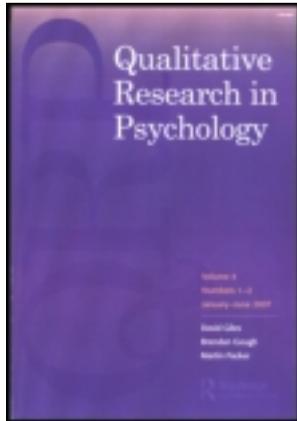


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Researching the Moral Dimension of First-Person Narratives

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Research with reflexive, narrative accounts has grown in popularity within psychology, not least because it legitimates the deployment of clinical skills. These skills are often directed toward evaluating the quality and substance of narratives according to criteria that are intrinsic to models of psychological well-being and clearly relate to professionally held moral goods. I describe a tension for the clinician-researcher between, on the one hand, evaluating a narrative according to widely accepted norms of “good” storytelling and, on the other, allowing the participants’ own ethical logic to be privileged. Using narrative extracts from a project on parents of transgendered teenagers, I illustrate these two broad approaches to reading reflective narrative accounts. I argue that we require more studies taking a direct interest in the ordinary, unremarkable work of ethical accounting within a local moral order. Research that focuses on the moral particularity of each participant could help us both in understanding the way that ethical reasoning guides action—grasping how participants’ uncertainties are expressed in the vocabulary of moral choice—and in deepening our scrutiny of the meaningfulness and relevance of our preferred clinical judgements and the ethical biases they reveal.

Keywords: ethical accounting; narrative research; psychological well-being; research reflexivity; transgender adolescents

Introduction

Recent years have seen a marked increase in the popularity of qualitative research in general and reflexive narrative accounts in particular in psychological research. Qualitative research by interview, eliciting participants’ self-revealing self-stories, is described in a host of recent publications and beginning to make a regular appearance in mainstream peer-review journals. More clinical psychologists in training elect to do “exploratory” first-person research, organising interviews around open-ended questions relating to “the (lived) experience of” participants. The aim is to generate rich data for qualitative analysis (usually a form of broadly thematic or narrative analysis). The elicited material we call reflexive narrative accounts; they refer to people’s tellings of significant events, predicaments and relationships in their lives. In such accounts people typically take the opportunity to interpret their behaviour and its effects, to explain or justify their actions and to articulate their intentions and understandings. Gough and Madill (2007) note that this kind of study is often taken to be paradigmatic of qualitative research.

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In this article, I argue that narrative accounts are always normative, always revealing the narrators' value-based assessments of their own wishes, intentions and actions and those of others. In turn, researchers who are clinicians often cannot forego the habitual clinical stance and regularly take up the opportunity to evaluate how good a narrative their participants offer. They typically look for evidence of various story-telling competencies, that is, a sense of agency, responsibility-taking, reflexivity, coherence, and so on, which have a strong ethical underpinning. I give some examples in what follows of studies (my own included) in which the researcher makes sense of participants' stories according to criteria that clearly link to ethical ideals which are themselves embedded in models of psychological well-being. I describe a tension for the clinician-researcher between, on the one hand, evaluating a narrative according to such widely accepted norms of good storying and, on the other, allowing participants' own ethical logic to be privileged. Using two short narratives from a project on the parents of transgendered teenagers, I illustrate these two broad approaches to analysing reflective narrative accounts.

The Artfulness of Reflexive Self-Narrative

Across a range of disciplines, the centrality of the narrative form in our ordinary social lives is widely recognised. The value of the form, for its potential to store knowledge and experience, its appeal to even very young children, and its ubiquity in their speech, all confirm this centrality. Of course "narrative" is always understood generously; people represent their experience in a host of forms—in excuses, complaints and explanations, ways that we could see as overlapping with narrative form. But whatever the form of telling, we tend to think of all narrative accounts as in some fashion constructed. Our psychological understanding in the fields of perception and memory have developed to the point where we handle ideas of "faithful" and "accurate" reporting with circumspection and appreciate the creative work involved in reporting on past events and experiences. Some events and experiences are not easily remembered or captured in words, and while there are physical and social constraints on the plotlines available to us, we have some freedom in the way we make and tell our stories.

Our inventiveness also comes into play when we refresh our narratives in the light of subsequent experience. Stories about important life events are often refined over time and across different contexts of telling; we edit and resignify the meaning of our feelings, intentions and beliefs. Shotter (1993) points to a distinction between backward-facing stories providing fairly coherent and well-organised accounts of remembered episodes, and forward-looking reviews (and re-reviews) which draw fragments of stories together in a new synthesis which may work for the narrator in a new way.

So despite the apparent simplicity of the storytelling template—beginning/purpose, middle/action-fact, end/outcome (Meyers 2004)—nothing about the telling or understanding of a story is simple. As Atkinson (1997) writes,

The ubiquity of the narrative and its centrality to everyday work are not license to simply to privilege those forms. . . . We need to attend to how socially shared resources of rhetoric and narrative are deployed to generate recognisable, plausible and culturally well-formed accounts. . . . Autobiographical accounts and self-revelations are as conventional and as artful as any other mode of representation. (Atkinson 1997, p. 341)

The work of Bruner (1990) on understanding people's self-stories as folk psychology has been influential in placing narrative centrally in contemporary psychology. For Bruner,

folk psychology is always a narrativised psychology and always interpretive. From the earliest stage of development, he argues, we are drawn to telling and listening to stories for their power in mitigating or at least making comprehensible a deviation from a canonical cultural pattern. The aim of a narrator is to negotiate a reasonably plausible account between the canonical demands of a culture and the idiosyncratic world of beliefs, desires and hopes. The task of mitigation is achieved, Bruner argues, by the storyteller appealing to the intentional states of the actors.

Reflexive Self-Narrative as Reports on a Moral Career

In clinical research studies with reflexive narrative accounts, the participants are almost invariably people in marginalised niches or in various kinds of problematic predicaments, whether mental health service users or not, for example, the physically or mentally unwell, the children of the ill, ill children, minority sexual groups. Their stories are of interest because they are about seeming departures from the norm. In open or semi-structured interviews, the participants are encouraged to talk at length about their situation, what they have endured, how they have coped, what they have learned, what impact their problem has had on their relationships and how they mean to face the future. A feature of such accounts elicited in open-ended interviews is often that they involve much justificatory talk about participants' actions, feelings, beliefs and stances. They typically involve making judgements about what participants did or ought to have done or might do in the future, and their critical evaluation of the actions and intentions of others. People even prepare for how their actions might be viewed in the future. In this way, narratives become sites for people to show how they managed agency and responsibility, how they negotiated ethical challenges; tellers are reporting on their moral career.

Reflexive Self-Narratives in Clinical Research: The Making and Display of Meaning

The popularity of research on reflexive narrative accounts amongst clinical researchers can be partly understood in recognising that it allows them to put to use their clinical skills. These skills include careful interviewing, following feedback, unpacking meanings and entertaining contradictory and multiple perspectives. As reflexive researchers, they also know to keep an eye on themselves as interviewers. Clinicians know that questions are interventive, never neutral, that interviews never simply elicit a story already known but contribute to the construction of a new account with its own effects Burck (2005). Clinicians also recognise that, as listeners, they have an active role in shaping the accounts they solicit. Our clients may offer well-rehearsed tales or may improvise a new tale, constrained by a sense of what they think the clinician will accept. The clinician is aware that her reaction—to accept or question the version presented—plays a part in the way the story develops and the way the storyteller's identity is reaffirmed, undermined or altered (Rosenwald 1992).

Potter and Hepburn (2005) have criticised qualitative researchers for, amongst other errors, their failure to account for the impact of the interviewer's role in eliciting accounts and their influence on shaping the material elicited. But clinicians for whom self-reflexivity is a consistent feature of their therapeutic practice will be aware of the constraints created by the interview context. They will recognise that for participants in research or clinical work, the recounting of the story offers an opportunity to both make meaning in particular ways *and* display their meaning-making skills.

Clinician's Evaluative Stance: Appraisal of a "Good" Story

When planning the skilful elicitation of such narrative accounts, the clinician-researcher faces the dilemma of selecting an appropriate and fruitful theoretical frame and method of analysis to guide the analytic work. If all narrations are normative, then it also the case that when clinicians listen to narratives in everyday work their stance is typically a highly interpretative and evaluative one: as clinicians, we assess clients' stories and our own reactions to them for clues about how to help, to intervene, to produce change. Using the framework of our preferred theories of psychological trouble and of change, we make an evaluation of the substance and quality of our client's narrative. We may assess its plausibility, its consistency across time and situations and its relation to the speaker's conduct in the room. We are alert to absences of self-awareness, authenticity, of a sense of agency, of appropriate concern for others. As clinicians we use these observations and interpretations to begin to hypothesise about how an account relates to the presenting problem, how it may allow for the possibility of new perspectives and new information, or to create a shift in understanding. Overall, we have a concern for what makes a good narrative, a concern driven by theories about how we understand the speaker's predicament and our ideas about how he or she can be helped.

One good example of such work is the study of Stern et al. (1999), who explored the accounts of a small number of carers coping with the sustained distress and disruption of an adult relative with psychosis. Based on their analysis of a small number of interviews carried out by a clinician, they describe the way that some carers managed to reconstruct a sense of their place on the world which enabled them to cope with the changes and articulate an understanding that was congruent with their belief system. Other carers could not find a narrative of the illness that moved their understanding on from the point of disruption; they were stuck with repetitive, "frozen" narratives which did not enable them to actively reconstruct a sense of their lives as meaningful in the face of the changes. One participant says about living with her daughter:

She makes me very upset and miserable . . . I cannot rest . . . all the time she is just quarrelling with me. She sees it as my fault . . . I do not feel happy with her around me. Anything I say, she takes it the wrong way and twists it. I do not think she can control it. . . . she should take her tablets, but she does not.

These researchers say that "in the face of profound disruption, containing stories of what is happening may emerge, or there may actually be 'narrative wreckage.'"

Using their clinical knowledge and experience, they boldly imply an evaluation of whether the story told by a participant is the best possible story, or even an adequate one, for taking his or her life forward from this point.

Frank's Evocative Categories of Illness Narratives

In a research project of my own, I elicited stories of parents living with an adolescent with atypical gender identity development (Wren 2002). In these accounts, the tellers certainly needed to account for their child's deviation from the canonical pattern of child development and, for many, their own deviation from the cultural norm of viewing transgenderism as alien and repellent. I analysed transcripts of long open-ended interviews. At one point in the analysis I borrowed the broad but evocative categories that Frank

(1998) developed for exploring the narratives of people with severe or chronic physical illness. What he termed the “restitution” story is the conventional or preferred illness story of getting ill, being treated and being restored to health. I argued that parents facing an adolescent’s gender conflicts might opt to perform, in the interview, a version of this illness account. Some stories revealed an expectation that therapy would enable the child to give up notions of transgenderism and get back on a “normal” developmental track. Alternatively, and still with restitution in mind, some parents hoped that if their child could speedily get sex reassignment treatment they would readily adjust to a new body and role, with past suffering and gender conflicts forgotten. Frank calls this kind of hopefulness “triumphant optimism.” One participant was the mother of Ollie, who has tried to live and be accepted in the male role for five years and now, aged fifteen, was hoping to have surgery confirming him as male. I interpreted her account as revealing a wish for certainty, clarity and coherence in the face of considerable emotional and practical complexity.

It makes it sound as if we all went ‘O alright Olly, fine.’ It wasn’t like that at all. But at the end of the day if that’s the way Olly is, or people can say, if you use the word ‘want,’ if that’s what Olly wants or if that’s what Olly needs or that’s what Olly is, whatever word you choose. He’s our family. It doesn’t make any difference, he’s still a living, caring person. People are multifaceted. His gender is actually at the end of the day his own business. He is still a really good person. He’s intelligent, he’s clever, he’s funny, and he’s caring. And that’s what we all want, an all-round . . . so ultimately his gender is his own business. What he needs is support . . . and I’ve looked at it through every angle and that’s the only area of conflict in his life. And it’s not conflict for him. It’s outside influences that cause him conflict. That’s why he couldn’t go to school for a long time. That’s why he’s very able to judge people instantly as to whether they’re going to be approachable or not. So conflict is with the other people definitely, not with Olly. Olly knows who he is. And to get the best from Olly, which ultimately benefits me as well, I’ve got to support him in who he is. Seems quite straightforward to me actually.

I argued that problems arise for restitution narratives when they are inadequate to fit the situation as events unfold. For example, parents of cross-gender adolescents may find that they have either demonised a condition that is not going to go away or have failed to take account of the physical and psychological impact of the transgender predicament, even after treatment. That is, there may be too ready an acceptance, or rejection, of the changes involved for everyone, with a concomitant bid for greater certainty than the situation allows or an unwillingness to live with the painful complexity of the young person’s situation. I will argue that elements of the latter are heard in the narrative of Olly’s mother.

By contrast, in the “quest story” illness is shown to be lived as a condition from which something can be learned and this learning can be passed on to others. The suffering now has some meaning and value. Such accounts can sound at times like restitution stories, but the difference lies in the way in which the reality of the problem and concomitant suffering are recognised and respected. The processes the parents describe are likely to involve sustained attempts to face up to the personal and social changes implicated in transgenderism and to see those as generating opportunities for change in the parents’ own sense of themselves. In telling their story as a quest, parents are forced to find a “grateful

life” (Frank 1998) in conditions that previously would have been considered unacceptable. Ben’s mother’s narrative has this quality.

Mother: It was just, I know Ben is stubborn but maybe this is why she has been stubborn. . . . that this doesn’t stop. I mean Ben would say things and then back off a bit but it was always coming back to it. And in a way Ben must be, I think I saw Ben as being very isolated without my support and I thought “that’s not right.” You know, I saw Ben going through all these problems on her own and I thought, “no.” This is the point where the parent felt “no, I want to be there. I’m sure it’s not beyond me to help Ben or just be there or learn a bit more.”

Interviewer: What did that mean to you in terms of the cost to you?

Mother: Nothing. No cost at all. Actually, I, Um, how can I put this into words? I was amazed that I would be the sort of person that would think that I’d be able to be in that position. I don’t know I’d never been in that sort of position before. Um I think I’d run away from things in the past. And this wasn’t going to go away. In a way I felt I was being utterly parental. That’s the only way I can say it. It was setting aside what I wanted and listening to what Ben wanted and saying “OK, I may have to take this a bit more slowly than you because you’ve been with this for a while. But I’m prepared to Um to listen to what you want.” And Um you know we had a conversation about the fact that we’d go on loving each other and that the spirit of Ben would still be there although this bit would be different. . . . I can remember crying at my loss of the wedding dress and babies but that was for me, that was crying for me.

Clinical Criteria for a “Good” Story

In reflecting on such qualitative narrative research endeavours, I want first to highlight the assumption, detectable in the research by Stern and colleagues and by myself, that in interpreting stories of significance, it is legitimate for the clinical-researcher to make judgements on the “quality” of the account. In these studies, the researchers seem to value such qualities of stories as uncertainty, the acknowledgement of complexity, hopefulness, self-reflexivity, a concern to establish personal meaning, and a readiness to explore and take up the responsibility to act. This seems a forward-looking evaluation by the researchers, with “goodness” framed in terms of how useful this narrative will be in carrying the teller forward in her or his future projects (Shotter 1993). The clinician-researcher asks: What are the consequences for this person of maintaining this narrative? How is the teller positioned vis a vis significant others? How will the narrative be used? In what ways does it implicate others? How does it apportion responsibility and blame? These questions betray the operation of powerful ideas, held by the clinician-researchers, about a “good” or “better” story.

There is in fact a surprising amount of convergence across different mainstream models of psychotherapy on what counts as a good narrative, linked to implicit ideas of psychological health and well-being. In the Attachment literature, on which clinicians of

several schools draw, the capacity to tell a compact, intelligible and perspicuous story about one's relational life, and to be aware of different perspectives, seems to be a critical part of resilience (Byng-Hall 1995; Fonagy et al. 1991; Walsh 2006). Underpinning this model has been the use of the Adult Attachment Interview (George, Kaplan & Main 1985) to elicit stories of past and current relationships and evaluate their quality as accounts. This analytic method, a form of discourse analysis, identifies characteristics of the narratives that refer both to form and content. Coherence, for example, describes a quality of storying that involves both plausibility and internal consistency, coupled with a tolerance for some uncertainty and contradiction.

Building on this analysis, Fonagy and Target (1997) have explored the capacity for "reflective function," detailing further the qualities of accounts that appear to be associated with psychological well-being. These include such things as the awareness of the opaqueness and defensive nature of mental states, the capacity to consider and tolerate different perspectives (the "otherness" of other minds) and emotional attunement. The validity of these criteria as markers of good psychological adjustment is shored up by empirical evidence that people who tell good quality stories of their relationships demonstrate secure attachments and transmit secure attachments to their children (Fonagy et al. 1991). Such good stories can be achieved regardless of early adverse experience. These ideas have been widely taken up by psychodynamic and systemic practitioners, and in the recent vogue for "mentalisation-based" treatments (Allen & Fonagy 2006).

In narrative therapy (e.g., White 2007), as well as in parts of the psychoanalytic narrative literature (e.g., Schafer 1992), it is the capacity for describing oneself and others differently that is the cornerstone of psychological change. Coming for therapy, people may bring narratives that exclude evidence of competence and well-being. The aspirations and commitments articulated in the client's narrative may constrain each other and set up conflicts and dilemmas. Clients are helped to consider the possibility of restoring their experience. The story is a living thing, and the clinician's job is to help the client creatively rewrite their account of events in such a way as to enable them to take the next step. Therapy involves developing an alternative story about a particular experience that makes as good a fit and might allow the teller to face the future more hopefully and courageously:

New discourses make new possibilities visible and new practices possible . . .
it is assumed that new accounts of the self permit the generation of new less-
problem-saturated self-experiences. (Avdi 2005, p. 494)

Working within a narrative frame, the clinician may be curious about whether people are describing themselves as passive victims of circumstance, or as purposeful agents, or perhaps both in different contexts. In a new narrative the client can develop a richer, more complex, less monological story about their difficulties, with a more realistic sense of agency (e.g., Lysaker, Lancaster & Lysaker 2003). Work may be needed to involve the client's significant others to sanction this new account (White 2007). Flaskas (2009) calls these new stories "transformative narratives."

For a clinician concerned with matters of authenticity and consistency, a good narrative also needs certain qualities that would convince the hearer of its integrity, distinguishing it from stories that seem to involve self-deception or defensiveness. According to the narrative researcher Rosenwald, in assessing narratives we should look at the connexions that exist among the series of stories any individual constructs over the course of a life;

a better story will contain more detail, be more complex and varied than its predecessors. Its generalisations will be supported by more instances. Rather than being free fictions, good stories are complex and layered; they retell the course of their own development (Rosenwald 1992).

Summarising in very broad terms the criteria for what would count as a “good” story across several different clinical models, valued stories are those in which the teller places herself centrally as an active agent, establishes the meaning and personal significance of the situation, incorporates disparate feelings and beliefs into a coherent and moderately consistent account (showing how the current story develops out of previous stories), builds empathy for the predicament of others and explores issues of responsibility. In a mainstream mental health context, difficulties with these competencies are seen as manifestations of an underlying illness or condition; indeed, we could understand therapy as the development of ways to promote these competencies or promote their recovery.

Clinical Research and the Participant as Ethical Subject

I am arguing that when clinicians carry out qualitative research with narrative accounts the values that these competencies embody—the values of empathy, reflexivity, a measure of coherence, consistency and so on—are frequently woven into the work of data analysis so that the research and clinical stances merge. Of course, as Jefferson and Hollway (2000) point out, the researcher, working with these values and identifying these competencies in the analysis, interacts with participants in a very different way from the clinician with a client. The interpretations of the researcher are not given directly back to the participant but are saved for further debate in the research community.

Nonetheless, it is striking that clinician and clinician-researcher alike are oriented towards sets of values that are concerned broadly with how people conduct themselves in relation to other people, that is, with matters of ethics. There is recognition in narrative research that at the core of the troubling predicaments people recount are ethical concerns about how others are affected by our behaviour; what is owing to others; what is owed to us; and concerns about trust, cruelty, vulnerability and blame. In such research, people are approached as ethical subjects, seen as creatures with cares, values and interpersonal commitments. Their recounting of a story of challenge and difficulty is, in part, as we saw earlier, an attempt to construct the meaning of the difficulty and the question of whether oneself, or others, might be responsible for it. Our vocabulary of personhood inescapably relies on what Taylor (1989) calls “strong evaluations,” that is “the distinctions and standards by which we judge our desires, feelings and actions as right and wrong, good or bad, better or worse, more or less worthy, and so forth” (Sugarman 2005). Our identities, our ideas about the kind of people we are or wish to be, are shaped by deliberating over what matters to us. What matters is worked through accepted interpretations of moral goods and standards developed and accepted in our social worlds (Taylor 1989).

We might think of the popularity of reflexive narrative accounts as evidence of a wider turn to ethics in clinical theory and research. This involves an acknowledgement that while not all motivation is moral, most social interactions come at some point to involve ethical expectations and judgements of the moral worth of ourselves and others. Expressed thus, this may be a novel perspective for some clinician-researchers: Leeming, Boyle and MacDonald (2009) studied people’s narratives of the experience of living with a mental health diagnosis. The researchers were surprised to find that their interviewees were very aware of the implications, for their perceived worth in the eye of others, of using a psycho-social rather than medical formulation of their difficulties.

Ethical Impulse in Psychology: Social Action as Morally Charged

One way of conceptualising this capacity for ethical evaluation is as an evolutionary development emerging in a complex social niche: the idea that morality is one way that our species adapts to social living. Implicitly, Fonagy's work takes this evolutionary view and cites the capacity for Reflective Function (RF) as an *automatic* capacity triggered or enhanced under certain circumstances and constrained under others, not a conscious and deliberate achievement (Fonagy & Target 1998), although its recovery may of course involve a considerable amount of conscious deliberation in the therapy room. For Bruner as well, folk psychology has its roots in our evolutionary past. In line with this preferred conceptualisation of how ethical awareness develops, recent debates in moral psychology focus on the question of how far our ethical judgements are determined by, on the one hand, rapid, automatic emotional processing which has an evolutionary history and, on the other hand, a more time-consuming cognitive consideration of ends and means (e.g., Greene 2007).

This evolutionary perspective allows the researcher/clinician to acknowledge the power of moral discourse in human affairs whilst also being faithful to the way in which the meta-language of psychology as a discipline has gradually moved from the moral to the technical. The development of morally neutral descriptive terms within theories of mental distress has been an important step in freeing us from religious accounts of mental illness and helped to establish psychology as a natural science, eschewing blaming accounts of mental disturbance. Indeed, it has come to be seen as a key characteristic of mainstream psychology that it "renders social action neutral" (Baumann 1993), deeming it neither good nor bad, and measuring it against technical rather than moral criteria.

A profoundly contrasting way of thinking about this turn to ethics in clinical theory and research is to consider the ethical impulse as foundational and elemental. The work of Levinas (see Baumann 1993) has been influential in detailing the experience of the other as alien and unknowable, while the impulse to care for and reach out to the other is primary; its advantages for our own well-being should be irrelevant. He argues that the core of being a person requires recognition from the other and a capacity to put oneself in the other's place.

These different conceptualisations of the ethical impulse can only be hinted at here. My argument is that clinical researchers, in eliciting reflexive narrative accounts, give themselves the opportunity to engage in serious appreciation of social action as morally charged. They can do this in two distinct but related ways. First, as we have seen, they can bring their clinical evaluations—saturated with moral meanings—to bear in interpreting their material. Second, they can respond with genuine curiosity to the complex, idiosyncratic ethical preoccupations of their participants, alive to hearing something new about the "strong evaluations" endorsed by participants (whether conforming to or resisting mainstream normative values).

Recognising the Contingency of Researcher Values

The first endeavour requires the researcher to evaluate the quality of a participant's narrative according to the values endorsed by the professional consensus. However, clinicians are not exempt from the necessity of establishing their integrity by showing reflexive awareness of the ethical assumptions they are bringing to the work. A commitment as a clinician to a set of high level abstract moral goods may distract the researcher from pursuing an understanding of the ways in which the participants make ethical judgements

about their own behaviours and the behaviour of others, especially if the participants and researcher inhabit different social niches. Narrative researchers need, in other words, to acknowledge the contingency of their values, rooted in a particular social context and class.

The vocabulary of morality in any moderately stable society may seem relatively fixed; nonetheless, the traditions within which we make commitments and judgments and the language we have to articulate them are not immutable. As Taylor (1989) reminds us, our moral predicaments have a history, and understanding this history can help us see the plurality of the goods we hold and the inevitable conflicts amongst them. Even if we are inclined to give up larger religious or philosophical meta-narratives, Rorty (1991) cautions us to hang on to those historical narratives which show our moral sources as partial, fallible and contingent. The dialogical, reflexive values and competencies I have identified as dominating clinical qualitative research may be billed as abstract universal goods but have in fact emerged within a particular cultural world. We cannot assume that our participants share a form of life where, for example, “agency” understood as “openness to relationship” is valued over “agency as self-containment” (Avdi 2005). Critics of the way that psychological expertise has increasingly become linked to authority concerning what it means to lead a good and worthwhile life (e.g., Rose 1996) are surely reminding us that the values the professional psychologist propounds, like self-reflexivity, increased responsibility-taking and appropriate self-discipline, are not timeless but may represent a universalising of the values from a distinct set of social conditions, what some have called middle-class values. Smail (1996) critiques the idea, linked to entrenched Western notions of the autonomous psychological self, that people can improve their subjective well-being by recognising the extent of their responsibility for their own mental troubles. Wood and Skeggs (2008), researching the narratives of people viewing reality television programmes, note how “just getting on with it” (“indefatigability”) and “not moaning” were key values amongst working class viewers, black and white.

I am saying, with no great originality, that clinician-researchers, analysing complex narrative accounts, need to critically address their interpretations. Reflexive qualitative research entails this work of second-order interpretation or “double hermeneutics.” The researcher’s own assumptions and preconceptions need to be subject to careful self-scrutiny. There is a need for “the interpretation of *the frames of reference of observer and observed*, for mediation of their respective understandings” (Sayers 1992, in Alexandrov 2009, italics added).

Recognising the Moral Authority of Participants

The second avenue open to reflexive qualitative researchers alive to the ethical dimension of narrative accounts is to address “the frame of reference of (the) observed” (Sayers 1992, in Alexandrov 2009). If qualitative clinical-researchers want to go beyond privileging their own interpretative viewpoints (however well scrutinised), they need to pay closer analytic attention to the way that people use language to reflect on the ethical dilemmas they face in their everyday lives. We require more studies taking a direct interest in the ordinary, unremarkable work of ethical accounting within a particular moral order. Researchers could become more curious about how their participants reason about their experiences of managing blame and criticism, identifying and negotiating around their contradictory moral impulses, pondering incompatible but equally legitimate responsibilities and wishes, disagreeing not only with others but with themselves. Of research interest would be the values that can be identified operating at a local level, that is, where “local” refers to particular cultural and social groupings, defined by gender or ethnicity, class or sexuality, or by their

location in relationships (as parent or child, therapist or patient), living in contexts with particular economic or structural features and facing particular life predicaments and challenges. While some narrators will refer to explicit moral rules or principles, researchers are just as likely to hear people working up what Rorty (1989) calls “a narrative of (our) own development, (our) idiosyncratic moral struggle, which is far more finely-textured, far more custom-tailored to (our) individual case, than the moral vocabulary which the philosophical tradition offers us” (Rorty 1989, p. 32).

Exploring the Moral Authority of the Researcher and the Researched

Returning to the two extracts quoted earlier from my research on parents of transgender adolescents, I offer some observations on my earlier analysis and some brief illustrative comments on how a more locally-focused reading might proceed.

Reflecting now on my earlier analysis (Wren 2002), I note my focus on the duties and responsibilities conferred by the social discourses of parent and mother and my clinical evaluation of how well my interviewees were served by the positions they took up within these discourses, as well as the implications of these positions for their child’s psychological well-being. I see how, as a clinician, I was especially interested in how much uncertainty each parent was able to tolerate with respect to her child’s gender struggles and the different ways each parent reported on the conflicts they had experienced in attempting to come to terms with their child’s claims. In my analysis I brought to bear a strong sense that a parent who was willing to expand her understanding of gender issues, to resist easy stereotypes and to embark on a painful journey of learning and self-examination would cope better with her child’s anomalous gender identity, and respond less judgementally. Hence, I was especially interested in (and impressed by) Ben’s mother’s growing awareness of her own capacity for reflective self-knowledge. By contrast, I saw Olly’s mother’s assertion that it “*seems quite straightforward to me actually*” as a disavowal of any sustained reflexive thinking. In my reading, Olly’s mother’s wish for coherence and (moral) clarity triumphed at the expense of a more tentative and complex picture of her own ethical struggle.

When I attempt to consider more fully what the extracts reveal about the particular moral values and commitments of the two participants, I am conscious of the partiality of this earlier analysis and the knowing assumption that my clinical evaluation of their narratives offered an adequate exposition. Here I briefly sketch an alternative, potentially richer reading. Both mothers present their feeling for family, and their mothering role, as a clear source of moral identity. Their central moral concern is what is owing to someone they care about, someone who is in trouble. For both women, these responsibilities mobilise a moral platform of “acceptance” with respect to their child’s gender identification.

For Olly’s mother, being “our family” implies an ethical commitment to accepting Olly in his preferred gender role. Acceptance, however, is not unconditional; there is an explicit hierarchy of worth. He must meet certain criteria, such as being “*caring*” and “*good*.” To also be “*intelligent*” and “*funny*” entitles him to further respect. She implies that a parent should initially contest what seem like rash or unwise choices in one’s children. (“*It makes it sound as if we all went ‘O alright Olly, fine.’ It wasn’t like that at all.*”) But once a child’s fundamental goodness and caring-ness are established, certain aspects of the self, such as gender identity, are deemed matters of personal privacy (“*his own business*”) and should not count for or against one in the evaluation of one’s worth as a person. Consistent with these precepts, Olly’s mother believes that it is irrelevant whether cross-gender identification is an illness, an impulse or an identity issue (“*if that’s the way Olly*

is if that's what Olly wants or if that's what Olly needs or that's what Olly is, whatever word you choose. He's our family. It doesn't make any difference"). It is not the business of the family to search for the meaning of the cross-gender identification, but to accord the young person privacy and support ("accept him for who he is"), assuming his good and caring qualities. The idea that this is a "straightforward" business can be seen as Olly's mother's moral insight, and not (as I first saw it) a defensive or glib dismissal of her own moral journey. Indeed, she makes little of her own struggle to accept Olly's transgenderism. One senses that she feels this would be a selfish preoccupation in the face of her child's need and suffering. There is no display of reflexive subjectivity; she makes no drama of the emotional labour of mothering (although she acknowledges that acceptance of Olly makes her life easier). There is only blame of those who are unkind and cruel to her child, and resistance to the negative value attributed to her child's problematic identity.

For Ben's mother, the moral imperative is to face up to things—the unknown, the unwelcome. She experiences a demand to be, or become, unselfish, to be ready to dismiss her conventional hopes and expectations ("setting aside what I wanted"). Self-transformation comes from the willingness to take time to listen properly, to "learn a bit" and not to run away. She finds new qualities in herself that enable this to happen. For her the situation is at once complex and simple, a struggle and yet a compellingly simple demand to "just be there." She articulates a range of moral platforms: we have evidence that she feels she can exercise something like rational and independent moral choice ("I think I saw Ben as being very isolated without my support and I thought 'that's not right.'"). But there is also evidence of her knowing what it is like to find out about herself in times of trouble ("I was amazed that I would be the sort of person that would think that I'd be able to be in that position. . . . Um, I think I'd run away from things in the past") (see Meyers 2004).

In these extracts (and indeed in the interviews as a whole), neither mother entertains the notion that responsibility for the transgenderism belongs with her, with the family or with the young person. Nor do they use dependence on a medical explanation of gender dysphoria to resist blame. They seem to have little time, unlike clinicians, for pondering causal explanations or psychological formulations; that is not their job. Being "utterly parental" involves accepting the child as he or she is. Their prejudice is in favour of seeing their young person's certainty and stubbornness as a guarantee of the integrity of their gender claims.

In this attempt to read more sensitively the moral position of the two mothers, I am struck that the values so favoured by clinicians are only patchily apparent in these extracts. Unlike clinicians, they are not, or are no longer, searching for explanations of psychological trouble rooted in deficiencies of self, for example, deficiencies of agency or self-reflexivity. Where these mothers might regard themselves deficient would be only in a lack of readiness to grasp the importance of the child's suffering, to support and accept him. Their moral authority resides in a fervent, and in some ways self-denying, reading of maternal loyalty. Yet in my initial analysis, I did not consider whether Olly's mother's reluctance to gaze inward was itself a moral stance.

Conclusion

Of course these two approaches to analysing narratives—evaluating narratives as a reflexive clinician and exploring participants' own ethical stances—are not exclusive but complementary. A researcher needs to be reflexively accountable for her own evaluations while also deferring to the moral authority of the person whose story is being represented.

With an emphasis on co-constructing the final reading of the text, the researcher/author should, while feeling entitled to make her own interpretation, also commit to thinking reflexively about her position and demonstrating sustained curiosity about the hierarchy of goods revealed in her participants' moral accounting. Reflexivity involves not simply an engagement in a process of self-examination about one's own moral stances but also a concern for one's accountability to one's participants.

Clinicians enjoy qualitative narrative research, I have argued, because it allows them to take an essentially interpretative stance, using their clinical skills to evaluate the quality and substance of narratives they elicit. But clinical-researchers have rival professional loyalties. Their commitment to a social science perspective requires them to be curious about the logic of their participants' accounts and reflexive about their own interpretations. As clinicians they also feel a pull towards judging the contribution of a participant's account to their putative psychological well-being. This may lead clinician-researchers to fail to do justice to the "lived moral life" (Brinkmann 2004) of their participants, to privilege their own strong evaluations to the point of indifference to the way different ethical stances may be operating in the participants' narratives. They may show too much judgement and not enough curiosity. We need to be consistently aware that a *quadruple* hermeneutic is operating: the participant judges the meaning and worth of her own actions, beliefs and intentions, then the participant's evaluations are judged by the clinician. Research that focuses on the moral particularity of each participant could itself help us both in understanding the way that ethical reasoning guides action, grasping how participants' uncertainties are expressed in the vocabulary of moral choice and in deepening our scrutiny of the meaningfulness and relevance of our preferred clinical judgments and the ethical biases they reveal.

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