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NARRATIVE INQUIRY

Attitude, Acts, Artifacts, and Analysis

Jill Yamasaki, Barbara F. Sharf, and Lynn M. Harter

"I am led to the proposition that there is no fiction or nonfiction as we commonly understand the distinction: there is only narrative."

E. L. Doctorow (1977, p. 231)

When Mr. Nelson, an 80-year-old widower, arrived by ambulance at the shock trauma unit, he had a collapsed lung, shattered pelvis, seven broken bones, multiple abrasions—and the remains of a leather leash clenched firmly in his hand. His distraught family explained he was walking his beloved dog, Patch, when a car hit them in the middle of a crosswalk near his home. The car continued forward, dragging Patch and Mr. Nelson, who refused to let go of the leash until, finally, it snapped.

When Dr. Duke, a 30-year veteran of the unit who "lives and breathes medicine and the hospital," met the ambulance, he saw an elderly, physically broken patient in emergent need. Mr. Nelson was alert but largely unresponsive, looking at Dr. Duke and trembling only when they gently pried the leash from his fingers. "What happened to the dog?" Dr. Duke asked the waiting family, later explaining he had a hunch it was worth asking. The family said Patch was alive, having only suffered minor scrapes, and safe with a neighbor who found him at the scene of the accident. "I've got to get this guy into surgery, and we've got to get this dog down to the hospital," Dr. Duke told a nurse.

When Donna, the co-founder of PAWS Houston, met Mr. Nelson's neighbor with Patch in the hospital lobby hours later, she learned that Patch had been inconsolable since the accident. He wouldn't eat, paced nonstop, and let out frequent sorrowful cries. Donna escorted the neighbor and Patch to the hospital's critical care unit, where a still-despondent

Mr. Nelson was recovering after the first of multiple surgeries. There, Donna watched as Patch, a 55-pound husky, gingerly crawled up the bed and nestled at his master's side. Moments later, Mr. Nelson visibly softened when he saw the companion he thought he'd lost, and he lifted his hand to pat Patch's head. They stayed that way together for an hour, when Dr. Duke returned to see his patient. "There are forces there between people and their dogs that I firmly believe we don't know and will never know," mused Donna out loud. "That may be," replied Dr. Duke, "but I know one thing. Not all caregivers are human."

We feel it particularly fitting to begin a chapter that explains narrative inquiry as a particular approach to health communication research with a story. Not just any story, but one carefully crafted from field notes, detailing informal tales told in ordinary conversations about extraordinary circumstances. It's the kind of material that often comes up in interactions with research participants, that powerfully makes a point, with meanings that remain with readers or listeners.

The initial story of Mr. Nelson and his beloved companion, Patch, as well as additional participant voices, photographs, and research design issues used throughout the chapter to illustrate our explanations come from an ongoing narrative project conducted by Jill (first author) and a team of graduate students in collaboration with PAWS (Pets Are Wonderful Support) Houston[1]. PAWS Houston is a volunteer-driven nonprofit organization dedicated to preserving the human–animal bond between people and their pets during periods of hospitalization for chronic and/or terminal illness. Its unique personal pet visitation program is available to all patients, except those in bone marrow units, through all major hospitals comprising Houston's Texas Medical Center, the largest medical complex in the world. PAWS Houston volunteers facilitate approximately 25 personal pet hospital visits each month, with more than 85 percent of those visits occurring in critical care. Visits require a physician's order, are usually arranged within 24 hours (or in as little as 30 minutes in end-of-life situations), and normally last about an hour.

In this chapter, we provide an overview of narrative inquiry with particular emphasis on the attitude of the analyst and the ubiquity of narrative material in a wide variety of discursive acts and verbal/visual artifacts for narrative analysis. To exemplify narrative inquiry in health communication research, we draw from and highlight the narrative work of multiple scholars (including our own), making sure throughout to acknowledge the method's strengths and challenges. First, we examine narrative as an orientation toward the study of social phenomena and detail the variety of sources available to and co-constructed by narrative scholars. Then, we discuss several alternative ways of anchoring and shaping analyses from a narrative perspective. As part of this discussion, we demonstrate how narrative analysis may proceed, using two brief excerpts from the PAWS

FIGURE 6.1 Patient and Dog

Houston project. We conclude the chapter with an acknowledgment and appreciation of narrative inquiry as an ultimately dialogic practice.

Seeking, Constructing, and Attending to Stories

Narrative inquiry entails a deliberate inclination to seek out and discern the storied elements within human depictions of life events to understand and convey inherent meanings. The search for coherency or sense making in a complex, confusing, ever-evolving, globalized world seems pervasive. References to narratives that frame events, including those that are problematic or discordant, occur in all kinds of commonplace activities—political debates, international diplomacy, cultural gatherings, religious rituals, social and commercial marketing, artistic renderings, family relationships, and, not least among these, interactions pertaining to healthcare, illness, and well-being. Thus, narrative inquiry also requires an aesthetic spirit, or the "boldness of the imagination," which physician and literary critic Rita Charon (2006) describes as "the courage to relinquish one's own coherent experience of the world for another's unexplored, unplumbed, potentially volatile viewpoint" (p. 122).

As an approach to health communication research, narrative inquiry is enacted through study objectives and design, and particularly the ways in which data are

elicited. Investigators with an *attitude* open to narrative sensibilities consider both the *acts* of making stories and the resulting textual *artifacts* as important areas of study. While conceptualizing and implementing their research project, this chapter's first author, Jill, and her students purposefully oriented to narrative (i.e., attitude). They recognized the narrative logics guiding the PAWS Houston personal pet hospital visitation program, posited overarching research questions regarding inherent and resulting narrative practices in the medical care that incorporates these visits, and invited stories from patient families, healthcare providers, and volunteers during informal interactions, semi-structured interviews, and participant observation. These relational acts yielded a variety of material artifacts for analysis, including transcribed interviews, field notes, and journals documenting their experiences as trained volunteers who facilitated pet visits and participated in various community outreach events. Additional artifacts collected during the study included PAWS Houston organizational materials, photographs, published articles, and patient reports submitted by volunteers after each visit. Importantly, as we demonstrate with the inclusion of the project in this chapter, narrative inquiry doesn't end with analysis. Our engagement with and representation of these artifacts is itself a narrative act, as is your engagement and understanding as the reader—an ongoing narrative process Arthur Frank calls "thinking with stories" (1995, p. 23).

Fisher (1987; Theory of the Narrative Paradigm) argues that most human communication is inherently organized in story form, but investigators can nonetheless encourage—or, conversely, discourage—participants in field research settings to provide rich, in-depth narrative responses. During interviews conducted for the PAWS Houston narrative project, Jill and her students asked family members, healthcare providers, and volunteers a series of open-ended questions in which they described their own roles and motivations for being involved with PAWS Houston, as well as the ways their views of healthcare have been influenced by participating in the pet visitation program. While several interview questions were aimed at evoking specific memories told in story form (e.g., favorite and least favorite aspects of their involvement, how they became involved with the organization, and typical experiences as part of the pet visitation program), at least one explicit item asked that the respondent share a personal story illustrating the mission of PAWS Houston. Wording interview questions in this way encourages participants to move away from general perceptions and impressionistic accounts to detailed descriptions of defining moments, what Flanagan (1954) aptly termed "critical incidents," often related with deeply felt emotions rekindled through the process of storytelling.

Narrative inquiry in the social sciences is most often associated with gathering data in the form of in-depth interviews; in essence, asking people to tell their stories. Interviews are typically audio- or video-recorded and then transcribed into written text. However, there are myriad other sources for accounts of

health-related experiences, including transcriptions of focus group discussions (which, after all, are group interviews); ethnographic field notes that detail the investigator's observations of contexts, interactions, and other phenomena, tending to focus on organizational or community settings (e.g., Ellingson, 2005; Mattingly, 1998); and recorded clinical interactions between health providers and care recipients (e.g., Charon, 2006; Kleinman, 1988; Sharf, 1990). Researchers are also tapping health narratives from less conventional data sources with increasing frequency. These include electronic forms of social media (e.g., Chou, Hunt, Folkers, & Augustson, 2011); photographs, video, art, and other visual formats (e.g., Harter & Hayward, 2010; Makoul, 1999; Radley, 2009; Yamasaki, 2010); television, radio, film, theatre, and other types of performance or entertainment education (e.g., Harter & Japp, 2001; Quinlan & Harter, 2010; Sharf & Freimuth, 1993); creative nonfiction in multiple forms, such as biographical and autobiographical depictions (e.g., Frank, 1991), personal journals (e.g., Tillman-Healey, 1996), and poetry (see Sharf, Harter, Yamasaki, & Haidet, 2011, for a combination of several data sources); and fictional literature that serves as a form of exemplary case study (e.g., Stanford et al., 1995; Yamasaki, 2009).

Narrative inquiry operates on the premise that storied meanings are inherent in human symbolic activities open to the interpretations of research participants and investigator-observers, and herein lies another essential aspect of this approach to scholarship. Narratives that are the focus of study are *necessarily co-constructed* by research participants and investigators; in some situations, the distinctions between these roles may merge into that of collaborators (e.g., Schneider, 2010). Social psychologist Elliott Mishler (1986) observed many years ago that research interviews are as much shaped by the questioner as the respondent, both by the questions asked, as we've previously discussed, as well as how the questioner responds to the informant's comments. The resulting narratives that emerge from these interviews are thus a byproduct of interviewer and interviewee reacting to one another. The process of transforming spoken discourse or field observations into written transcriptions is also a significant form of story editing and co-construction (Mishler, 1991; Riessman, 2008) that is part of the broader undertaking of interpretation (i.e., discerning patterns within and assigning meanings to the various sorts of texts, verbal and visual, selected for a particular research project).

In essence, narrative inquiry requires a sensitivity to attending to discourse and other symbolic forms in terms of their narrative elements, such as plots and characters, accentuated by research designs and questions that encourage participants to provide storied accounts. It also necessitates a realization that stories are related in multiple formats and media, with an openness toward delving into whichever of these may provide ways of understanding queries guiding the investigation.

Approaches to Narrative Analysis

Once data have been identified or elicited, narrative analysis commences. We wish to assert right away that there are many different approaches to analysis, with no one approach especially preferred (for a broad sampling of various narrative analyses, see Harter, Japp, and Beck's 2005 landmark collection); in fact, researchers define what constitutes a narrative in various ways. In her splendid text on narrative methods, sociologist Catherine Riessman (2008) proposes four main analytic categories in which to group several different ways of interpreting narrative texts: thematic, structural, dialogic-performance, and visual. For each category, she delineates certain attributes and chooses exemplars from studies conducted from various social sciences and education to illustrate how investigators have approached their work. In this section, we will briefly allude to those categories, while also elaborating on other issues endemic to conducting narrative analyses that we've learned from our own research experiences.

As a starting point, the analyst must assess the elements of story within the texts under examination. In their most basic forms, these aspects of narrative are not esoteric concepts, but, rather, familiar features recognizable from childhood. Most essential is the idea of *plot*, in which a series of events lead to a tensional situation needing to be resolved. In the words of psychologist Jerome Bruner (1986), a plot is "a plight into which characters have fallen as a result of intentions that have gone awry either because of circumstances, of the 'character of characters,' or most likely of the interaction between the two" (p. 21). Thus, the second necessary narrative feature is that of *characters*, the people or beings implicated within the plot. Other story elements that contribute to our interest and understanding are *motives*, or why characters make certain choices and take particular actions; *scene*, the locale and surroundings in which events transpire; *time or chronology*, the sequence in which the plot is revealed or the temporal orientation of the characters; and *values and life lessons*, the ethical implications and consequences of how the plot is resolved, what rhetorical and literary theorist Kenneth Burke (1984/1935) famously referred to as "equipment for living." Additionally, narrative analysis may take into consideration *context*, the surrounding circumstances in which a narrative is communicated, including the presence of particular audiences; and *storytelling*, the style and means in which the story is conveyed.

As with other kinds of analytic frameworks, it's unlikely that all aspects of narrative will be equally salient in interpreting a particular text or set of texts. While plot and character seem fundamental, other features may not be as compelling or significant, although all should be considered in what Charon (2006) calls a "close reading." Meanwhile, narratives are rarely self-contained and structured linguistic events (i.e., beginning, climax, end), having aptly been referred to as "unruly texts" (Charon & Taylor, 1997). Boje (2001, 2008) argues that stories often unfold, during interviews and in the field settings, as fragments not nearly as tidy or coherent as typically portrayed in academic theorizing.

Boje cautioned researchers against imposing a "counterfeit coherence" (2001, p. 2) on participants' accounts. That said, researchers can still attend to narrative aspects of fragmented accounts—disruption, time, space, characters and their motives. We have reproduced a table of questions inspired by narrative theory initially published in Harter's (2013) articulation of the poetics and politics of storytelling in health contexts.[2]

Depending on their training and perspectives, narrative scholars focus at varying levels of magnitude and specificity in the data. At the broadest level of generality and applicability are master- or meta-narratives. This term refers to

TABLE 6.1 Questions Inspired by Narrative Theory

Characters
• How are characters and actions organized in time and space? • What archetypal characters live in stories (heroes, antagonists)? Who is chosen? Who is barred? Who is not eligible or qualified to enact certain roles?
Setting/Context
• What is the setting(s) of the actions? What is the setting(s) of the storytelling? • How do contexts give rise to particular stories? • How does storytelling reveal conditions of its production? • What sorts of actions or developments does the setting suggest and/or require? • What recurrent patterns of human symbolizing are developed and reinforced by conditions of living? • What narrative conventions are privileged in particular contexts? • What stories are (re)told in particular contexts until they become taken for granted?
Plot/Arrangement and Timing of Events
• How are the past and future envisioned in light of present circumstances? • Why is the succession of events configured in this way? • How did the outcome come about? • What events and actions contributed to the solution? • Are there inconsistencies that suggest alternative narratives? • Where are the gaps in stories? Narrative silences? The unmentioned or unmentionable? Absence of some stories altogether?
Storytelling Activities and Relationships
• Who is narrating? • Who composes the anticipated audience? • To whom are stories told? • How do stories position readers? • What duties are incurred by virtue of witnessing a story? • What does the process of narrating do?

(Continued)

TABLE 6.1 (*Continued*)

Consequences of Narratives
• What does the story accomplish? • What are the consequences produced by particular stories? • What social orders are maintained or disrupted through storytelling? • What subjectivities/identities are called into being by stories? • What new possibilities do stories introduce for being in this world? • Under what conditions is storytelling therapeutic? • How do stories evolve and change over time as various constituencies render their experience in alternate stories?
Purposes/Motivations of Narratives
• What worldviews are reflected in stories? • What cultural markers of concern are revealed in narratives? • Whose interests are served (or not) by stories? • What stories are told to justify actions? Relationships? • What motives are assigned to characters through storytelling?

story genres or types characterized by a broad theme or function, often reflective of particular ideologies, assumptions, and values. For instance, Japp and Japp (2005) describe the master narrative of biomedicine, dominant with both experts and the public, as one that explains and treats disease on the basis of scientific validation with measurable, objective evidence. In response, the authors describe the existence of a counter, meta-narrative of "legitimacy" that resists scientific confirmation where it does not exist in favor of individual testimonies of suffering. In a second example, as individuals live longer and with more chronic illness, narrative gerontologists (e.g., Kenyon, Bohlmeijer, & Randall, 2011) have turned attention to the "inside of aging" to counter the longstanding master narrative of aging as decline with a meta-narrative of successful or healthy aging. This perspective moves beyond the biological to a more complex view of aging by focusing instead on the ways in which elderly individuals maintain quality of life and an overall state of well-being by satisfactorily coping with or creatively adapting to age-related challenges. On the basis of examining many individual stories of life-threatening or life-changing illness, Frank (1995), in a third well-known example, developed a typology of master narratives of restoration, chaos, and quest. Informed by Frank and others, Mattingly (2010), drawing on ten years of fieldwork in urban healthcare settings populated by African American families, explored how the practice of hope is connected to and shaped by canonical narratives. Hope, when guided by a quest-like vision of transformation, cannot be reduced to restorative "success" or "cure" often embodied in "clinical hope."

Mid-level analysis accounts for much of the interpretive work on narrative texts done by health communication scholars. Such projects may focus on one

exemplary text or sets of texts that are somehow related. Stories may be defined as an entire text, such as an interview, series of interviews, or sets of field notes, or as particularly meaningful episodes within a larger text. One variant of mid-level analysis has a biographical or life-history focus (e.g., de Souza, 2010). More frequently, such studies fall within the category of thematic analyses that are concerned with discursive content. While thematic analyses of various types are common throughout all interpretive work, Riessman (2008) makes the important distinction that "narrative scholars keep a story 'intact' by theorizing from the case rather than from component themes (categories) across cases" (p. 53). The analytic process may be informed and shaped by pre-existing theory (e.g., Adelman & Frey, 1997), or theory may emerge from data immersion (e.g., Geist-Martin, Sharf, & Jeha, 2008). Unlike grounded theory analyses across cases, there is no primary template or series of steps to follow. And, although not required, such analyses frequently consider contextual issues as well as text (e.g., Young & Rodriguez, 2006).

Micro-level analysis is less frequently practiced within health communication research, although used more extensively in other fields of study. While content remains an important concern, microanalysis tends to explore how meaning is derived through examination of structural elements. Much more than thematic analyses, the focus is on the transcribed text, including some paralinguistic elements such as pauses, typically to the exclusion of context. Because of the painstaking attention to detail within transcribed material, the concept of narrative shifts to bounded verbal episodes; in other words, a one-hour interview transcript may be the source of several identifiable stories, each amenable to analysis. Microanalysis generally involves some form of deconstruction of discourse to discover underlying meanings and/or conversation dynamics. Two well-known approaches involve the parsing of narratives into component parts, as described by sociolinguist William Labov, or the rearrangement of story fragments into poetic stanzas, as explained by educational literacy scholar James Gee (for fuller explanation of these techniques, see Riessman, 2008, pp. 77–100). As with every systematized analytic strategy to reveal discursive structure, including more familiar communication methods such as fantasy theme or pentadic analysis, reducing the interpretive process to a set of repetitive steps does not usually lead to rich insights. When used skillfully, however, these frameworks provide a point of departure for in-depth investigations of verbalized narratives, as exemplified by Beach's (2009) study of family conversations about a member experiencing cancer, physician and critical theorist Howard Waitzkin's (1991) detailed examination of the ways patients' attempts to discuss psychosocial concerns with their physicians become marginalized, or Ellingson's (2011) study of the construction and performance of dialysis technicians' professional identity.

Riessman's other two categories of narrative analysis—dialogic-performance and visual—draw attention to particular forms of materials and ways of presenting

analyses of stories. It is important to underscore that, for several of the exemplary works cited in this chapter, the analysts themselves use a story-like format to discuss their interpretations of narratives. In other words, this form of scholarship is concerned with artfulness as well as argument, evocation as well as evidence.

What we prefer to call "performative analysis" focuses on the manner in which stories are told, and how the process of telling enhances the meaning of the story's content. Among others, communication scholars who conduct this type of analysis produce autoethnographic and embodied dialogues, reenactments, and performances of lived health and illness experiences. Noteworthy examples include Ellis and Bochner's (1991) reenacted autoethnographic dialogue about personal decision making regarding abortion; Langellier's (2001) dialogue with a breast cancer survivor concerning her decision to tattoo her mastectomy scar as a way of performing her changed identity; Vande Berg and Trujillo's (2008) relational account of cancer as told in two voices; Aleman and Helfrich's (2010) collaborative tale of dementia as narrated by both mother and daughter; Taft-Kaufman and Carilli's (2011) collaborative script about the communication issues surrounding a cancer diagnosis; Defenbaugh's (2011) autoethnographic and embodied performances of life with inflammable bowel disease; and Schneider's (2010) participatory research with adults who have schizophrenia and are homeless, resulting in such autoethnographic collaborations as a readers' theatre, photovoice exhibit, graphic novel, and documentary film.

Although not as prominent in health communication, visual analysis has become increasingly frequent throughout communication studies. In this approach, investigators regard visual artifacts, such as photographs, drawings, film, and video, as narrative media, either alone or, more often, in conjunction with verbal discourse. Researchers may encourage participants to produce visual artifacts as a way of eliciting health narratives, especially from those unaccustomed to giving voice to their experiences and concerns (Makoul, 1999; Wang, 2003; Yamasaki, 2010). The photographs used in this chapter were provided by PAWS Houston, but not taken by participants or correlated with particular interviews. Still, they offer powerful ways of communicating the undeniable bonds and therapeutic impact between very ill patients and their canine companions, neither of whom may have the capacity for speech. Indeed, visual media can serve as a powerful means of conveying the results of narrative analyses, as demonstrated in the award-winning documentary films produced by performance studies scholar Dwight Conquergood (Seigel & Conquergood, 2008/1984) on the health of Hmong immigrants, as well as in the film co-produced by Lynn Harter, one of the authors of the present chapter, on the experiences of families living "new normals" with pediatric cancer (Harter & Haywood, 2010).

In what follows, referring to the above explanation of different analytical approaches, we demonstrate a brief narrative analysis of two excerpts from the PAWS Houston project. Both excerpts are bounded interactions from longer transcripts of interviews conducted with volunteers who facilitate the personal

FIGURE 6.2 Doctor and Dog

pet hospital visits. Each exemplar reveals how different types of stories emerge, are encouraged, or are co-constructed through the interview process.

Transcript 1: An Exemplary Story

DAVID (INTERVIEWER): You've mentioned the patient in ICU a couple times. What made that visit so meaningful for you?

VICKIE (VOLUNTEER): Well, she had been in the ICU for a long time. She had a major stroke that had affected her dominant side—her right side—so she couldn't move it very much. She was still on a ventilator after quite a long time because she had a tracheostomy. Her husband just felt it was very important for her to see her dogs. Her dogs were dachshunds. There were two of them, so we needed two volunteers because it's one volunteer for each animal to visit the family. I went in first because I'm an ICU nurse and I wanted to make sure that the other volunteer, who wasn't a nurse, would be okay in this situation.

DAVID: Right. Good.

VICKIE: And I went in with the husband and the dog that the lady favored the most. The husband was worried that the dog wouldn't behave properly,

so he carried the dog and was really kind of nervous the whole time. I reassured him that usually what the animals do is just lay right down because they understand. They know that this is their human and that they need to be calm.

DAVID: Really!

VICKIE: Yeah, and that is exactly what happened with this dog. He laid him on the bed, and the dog went right to the lady, laid his head on the lady, and stayed there the whole time. The lady, actually, who was right-handed, tried to move her right hand to pet the dog, which was a huge thing. And then, on top of that, the man was telling me stories. Oftentimes, these people just need to talk about their animal, too, but, of course, the lady couldn't talk to me. So the man was telling me how, every morning, she used to wake up and feed this dog a cup of coffee. [*laughs*] And, after she had her stroke and came to the hospital, he had to learn how to make coffee for the dog because the dog was having caffeine withdrawals. [*laughs*] And, as he's telling me all these stories, the lady—the patient—started sticking her tongue out over and over and over. And the man got very nervous and said, "Oh, my gosh, I don't know what's wrong with her. She's never done that before. Maybe she's having a seizure." And I said, "Sir, I think she's missing her coffee." And she looked directly at me. And I said, "I'm so sorry that you're missing your coffee. I'm sure you would like to have some coffee right now." And she nodded her head yes, and I said, "Right now, they can't give you any coffee, but hopefully, eventually, you can have coffee." We were able to ascertain that she understands exactly what we were talking about. So I went to the nurse, and I explained the situation, and I said, "Please let her know anything you are doing to her because she is there. She understands what's going on. She just can't communicate back to you."

DAVID: That's incredible. You made a huge difference.

VICKIE: Yeah, I was able to make a huge difference for that patient because we saw that she could move her affected side when she tried to pet her dog, and we were able to ascertain that she understands what's going on. And, after we switched out dogs and the husband came out, he said, "I can't believe how calm the dog is. He was so crazy and hyper all the way here, but now it's like he understands where she's been and what's going on." And that's exactly what happens over and over again.

DAVID: The animals are wondering what's going on, too.

VICKIE: Yes! They're missing their family member. And they go in, and they see their family member, and they know right away. So, then, all is okay for the animal. The animal benefits so much more than people understand. The family benefits because they see their family member is still there. And the patient benefits because she loves this animal. This animal is so much a part of her life that she's trying to move part of her body that she thought she couldn't move. And, not only that, we were able to understand that she knew what was going on.

DAVID: And it sounds like you benefit, too.

VICKIE: And I get to witness it all. I'm the lucky party that gets to sit there, and I get nothing but positive out of it because I get to see all these good things happening.

A close reading of the interaction between David and Vickie reveals how various narrative elements combine to create an exemplary story that ties together the therapeutic benefits for everyone involved in a personal pet hospital visit. The plot is both simple and profound: A visit with her favorite dog results in significant breakthroughs for an immobile, nonverbal patient and, by association, her husband and healthcare providers. Because of the dog's presence, the patient attempts to move her right hand, tries to communicate, and indicates comprehension. The patient and her dog are major characters; supporting characters include her husband and the PAWS Houston volunteer, who also happens to be a nurse. As a bounded part of a much longer transcript, the story is a testament to the PAWS Houston program, in particular, and companion animal hospital visits, in general. It also illustrates how David's deft reflections contribute to the ongoing conversation and extend the story, culminating in Vickie's poignant summary of the overarching values exemplified in one especially memorable visit.

Transcript 2: Interlocking Stories

RENEE (INTERVIEWER): Do any visits, in particular, stand out for you as a volunteer?

STACY (VOLUNTEER): Once, I took a pet to visit a young man. He had been in some sort of accident and had multiple fractures, so he was stuck in bed. [Oh.] His friend had actually arranged to bring the dog for him. Clearly, to me, he didn't have that much close family surrounding him. [Oh.] I don't think he was aware the dog was coming to visit. He was just so shocked and surprised, and he started crying. [Aw.] The friend handed her to him, and he was just hugging her and crying. He was so happy to see her.

RENEE: Oh, how sweet.

STACY: Yeah, that one really stands out in my mind because it's not always an emotion you expect from a strong young man. [Right.] For him to show

that much emotion just showed me how much that dog meant to him, and it made me feel good that I could help make that happen.

RENEE: It must be very rewarding.

STACY: Yes.

RENEE: What's the best part?

STACY: Far and away, it's the interactions I get to see with patients and their pets. [Yeah.] You know, I work in the hospital so I see therapy dogs come through, but I think it's infinitely better to have the patient's own dog there because it's basically a family member they probably thought they wouldn't get to see while they're in the hospital. [Yeah.] The relationship is already there. [Sure.] And they're often very close to their pets in a different way than they are with their relatives. It's a much more profound experience for them, and they get a lot more out of the visit, because they're connecting with their own family member versus another person's animal.

RENEE: Is that what drew you to PAWS?

STACY: Yes. I worked in a doctor's office before I went to medical school, and I had seen their brochures around, and I thought it sounded interesting and neat. [Yeah.] I hadn't really sought them out. [Sure.] Then, when I went to medical school, one of my professors arranged for PAWS to come give a presentation asking for volunteers, and I got to hear the full story about what they did. [Oh, wow.] Part of why I got into it is because I love animals. I have dogs, and it's something I would definitely want arranged for me if I went into the hospital. [Sure.] And then the fact that I was going into medicine; I hadn't yet been exposed to patients that much yet, and I thought that volunteering would get me into the hospital and interacting with patients.

RENEE: Sure. Wow, I didn't realize you were a doctor. Do you still volunteer?

STACY: Yes. I usually try to facilitate two or three visits a month.

RENEE: That's great. So, do the visits influence what you do as a doctor, too?

STACY: Certainly. [Sure.] For me, as a physician, it gives me a different perspective on some other things we can offer a patient, especially because in the hospital you need a physician order to allow a pet to visit. [Right.] And, at this point in my career, I'm able to write those orders and get it moving. [Yeah.] It's something I know a lot about, and it's something that maybe the physicians I'm working with aren't aware of as an option. [Sure.] I've had some patients that are in the hospital for up to two months or more. [Oh, wow.] Having that as one of the things we can offer, I think, makes a big difference. It changes their hospital experience, too.

RENEE: How so?

STACY: I mean, seeing patients day to day with their family, yeah they're happy to see them, but you don't see that emotion like you see when you bring their dog in the room. [Sure.] And the fact that they just get so excited and overwhelmed and overjoyed to see their pets, that's the best part of it. [Yeah.] For that brief amount of time—like with that young man who was so broken . . .

RENEE: The one who had multiple fractures from an accident?

STACY: Yes. He was so broken, you know, physically and emotionally, but you can get their mind off the hospital and provide them with that connection and that feeling of unconditional love they can only get from their pet. [Sure.] I see it as soon as I go in the door. I think it's a lot closer to them being at home than just having a family member come visit. It's a little bit more personable.

The interaction between Renee and Stacy demonstrates how the overarching story of PAWS Houston is necessarily enacted through individuals and their stories. In a short space taken from a much longer transcript, three interlocking stories reveal ways the PAWS Houston personal pet visitation program works for different participants. The first story, about a physically and emotionally broken young man's powerful reaction to seeing his dog, illustrates the therapeutic benefits of companion pet visits for hospitalized patients. In the second story, Stacy recounts how the PAWS Houston personal pet visitation program benefited her as a volunteer wanting to interact with patients while studying to become a doctor. The third story reveals how the program provides Stacy, now a doctor, with an additional therapeutic option for her patients. While each story is distinct, larger themes cut across them all, including (a) Stacy's repeated observations that companion pet visits are "infinitely better" than visits from therapy dogs and a "much more profound experience" than visits from family members and (b) the patient-centered care and humanizing medicine that are inherent in the PAWS Houston personal pet visitation program, and endorsed by medical professionals in their educational settings, volunteer efforts, and treatment practices. Finally, Renee's conversation with Stacy demonstrates how narratively sensitive investigators who listen attentively to their participants can move beyond the interview guide to co-construct organic stories that may, ultimately, reveal more than they could have originally anticipated or previously imagined.

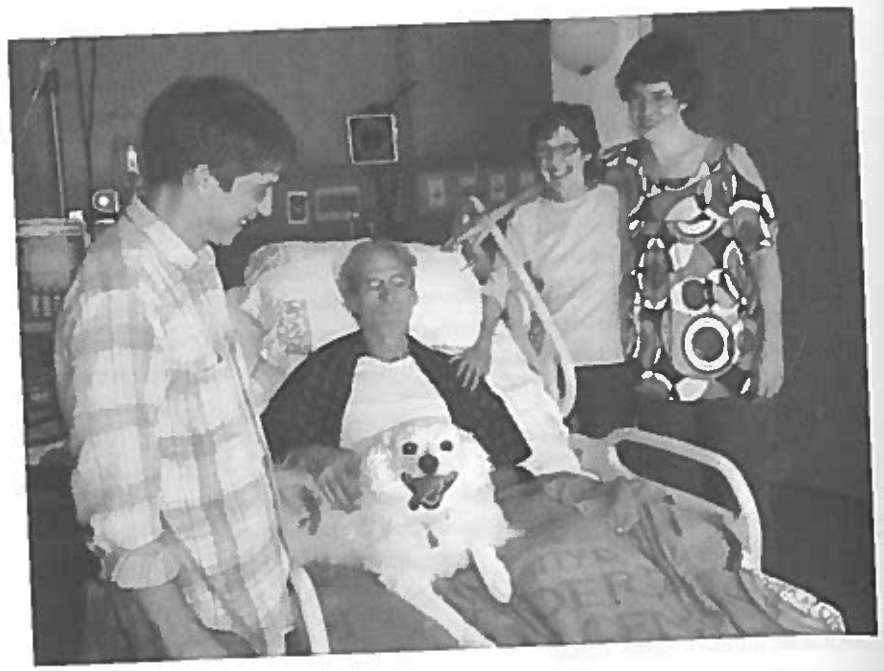

FIGURE 6.3 Family and Dog

Narrative Inquiry as Dialogic Scholarship

> "Thinking *with* stories is a process in which we as thinkers do not so much work on narrative as take the radical step back, almost a return to childhood experience, of allowing narrative to work on us."
>
> *David B. Morris (2001, p. 55, emphasis in original)*

In this chapter, we have defined narrative inquiry with an emphasis on the inclination of the analyst to recognize and attend to the storied elements within human depictions of life events in order to understand and convey inherent meanings. We have delineated the most common qualitative data sources in health communication research that may lend themselves to narrative analysis. Although there is no one favored way of doing narrative analysis, we have explained the elements and perspectives from which narrative studies of field data emanate. To demonstrate, we conducted analyses of two brief examples, applying many of those same features with short narratives excerpted from recently collected data in the ongoing PAWS Houston project. Throughout, we have consciously woven analytic complexity with emotion, description with illustration.

Our chapter both demonstrates and produces the relational ways of knowing inherent in the telling and sharing of stories. As narrative inquiry continues to grow in popularity and prominence, particularly in research concerning issues of

health and illness, Frank (2005; 2010) suggests narrative scholars purposefully move beyond the inner workings of the storyteller to understand what stories *do* for story-listeners. What specific capacities do stories have to stretch and expand existing storylines? How do stories work *on* people, affecting what they see as real or possible and shaping their understandings or behaviors in particular ways (e.g., Harter, 2013)? These questions point to the importance of dialogic narrative analysis. Meanwhile, as suggested by Frank (2005), a dialogic standpoint acknowledges the "unfinalizability" of persons and events featured in storytelling and the "perpetual generation" of narrative analysis. "One story *calls forth* another," argued Frank. "The point of any present story is its potential for revision and redistribution in future stories" (p. 967, emphasis in original). From this perspective, narrative analysis ought not claim a final word, but, instead, stimulate ongoing sense making.

Just as the PAWS Houston personal pet visitation program shapes the lived experiences of its participants and the stories elicited by and co-constructed with the research team, we interpret and share stories from the PAWS Houston narrative project with you, the reader, who then constructs your own interpretations in context with the chapter and your own lived experiences. Toward that end, we close with a reflection from Lisa's journal, written after an afternoon of volunteering in the PAWS Houston booth at a community outreach event.

> Working with PAWS Houston this semester has opened my eyes to what it would mean if I couldn't have Murphy, if I couldn't reach for her when I felt pain or needed comfort or knew I was stuck in the hospital or realized I wasn't coming home. That's what I told people visiting the booth today, and everyone instantly agreed. People love the PAWS pet visitation program because it's what they'd want, too. And then one woman came up to the booth and said the most amazing thing. She told me she was waiting for a liver, and she panicked when they put her on the waiting list. "They told me I would be away from home for 60 days!" she said. She didn't worry about her family because she knew they would be with her, but she panicked because she wouldn't see her dog. She actually told me it was a bigger relief to make contact with PAWS Houston and know they'd arrange a visit when the time comes than it will be when she gets the call from the registry. I'll never forget hearing her say that. Before she walked away, I gave her a hug and wished her well and said her story could be mine. If I were in her shoes, I'd feel the same way.

Notes

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CONVERSATION ANALYSIS

Understanding the Structure of Health Talk

Christopher J. Koenig and Jeffrey D. Robinson

Conversation analysis (hereafter CA) represents a naturalistic and inductive approach to the study of generalizable patterns of interaction that are ultimately amenable to quantification (Robinson, 2007). CA originated at the University of California during the 1960s and has its roots in the work of Erving Goffman and Harold Garfinkel (for reviews, see Heritage, 1984a). CA is now the dominant, contemporary, and methodological framework for the analysis of social interaction (Heritage, 2009). As Robinson (2012) reviewed, CA primarily deals with three questions that are fundamental to communication research:

1. How do speakers 'make sense' or 'make meaning' when they talk, and, similarly, how do listeners know what speakers 'mean' when they talk;
2. How does an utterance's meaning affect subsequent talk; and
3. How does an utterance's meaning affect speakers' 'relationship' with each other?

An alternative method for studying provider–client interaction is the use of pre-existing coding schemata (Roter & Larson, 2002) to divide interaction into component speech acts and place them into mutually exclusive categories, which allows for the generation of frequency counts that can be statistically associated with other variables (for review, see Heritage & Maynard, 2006). However, coding is not itself a method for describing and explaining the social organization of interaction, per se, which is the purview of CA. As Robinson (2011) argued, there has been a social-scientifically pragmatic and symbiotic relationship between CA and traditional coding methods, the former bringing validity to the latter, and the latter empowering the former.