

What Is a Good Story?

By Jaber F. Gubrium

There are all kinds of stories, from the founding sagas of nations and accounts of social change to narratives of growing up, overcoming life hurdles, and adjusting

to a new environment. Some stories are fictional, some disinformation (deliberately deceptive), others are presented as true descriptions of what really happened, or would have happened if circumstances had been different. Whether stories center on individuals or larger social forms such as families and communities, and however true to life they are, stories are part and parcel of the way we know ourselves and our world. Indeed, it has been said that life comes to us in the form of stories—we do not have unmediated access to our lives, but rather we know them through stories. Narrative is an integral feature of experience, not merely a conduit for representing it.

That narrative is part of experience is evident in the ordinary ways we respond to things and events. A life crisis, such as a divorce or the death of a loved one, is not so much known in its immediate ebb and flow as through attempts to understand what has happened and to construct a framework for responding to it. These attempts are full of narrative, as a divorce, say, is thought through, reflected upon, come to terms with, or lamented endlessly in the various account-

*Help for caregivers of
people with dementia.*

ings we and others bring to the matter (see Riessman, 1990). The story of someone else's divorce may bring light to, and a different way of accounting for, one's own divorce,

with the resulting emotional and moral consequences. A new way of viewing future prospects for collective solidarity, embedded in a widely shared narrative of ethnic identity, functions similarly, for good or ill (compare Edelman, 1967; Rosenwald and Ochberg, 1992; Nagel, 1997).

My concern is with personal narratives, especially stories told about caring and caregiving in relation to Alzheimer's disease (Gubrium, 2000). Here, too, experience comes to us in the form of stories. What we and others relate about growing old, how we care for ourselves and for others, and the prospects for living with dementia, is drawn through the various ways we view the story of what has happened. In particular, I am concerned with the good story, the narrative that provides a satisfactory understanding of aging, caregiving, and cognitive impairment. The good story does not always convey good news. Rather it is satisfactory because it relates well to what we otherwise sense has happened or will happen, the sense of which is also mediated by stories. The good story is good because, for better or worse, it

fits our views of what a proper or useful narrative of the subject matter would be.

My research has centered on how stories work in practice, focused in this case on how those who care for people with Alzheimer's disease assemble satisfactory understandings of their experience (Gubrium, 1986; Gubrium and Lynott, 1985). It is an important question because those concerned seek understanding in order to take what they believe are appropriate actions in their situations. In everyday life, making decisions and taking action are not the consequence of a predetermined calculus of costs and benefits, rationality, and risk factors. Rather, costs, benefits, sound reasoning, and risk, among other things, are narratively organized; they are articulated and understood through storytelling.

CRITERIA FOR THE GOOD STORY

The research showed initially that satisfactory narratives centered on familiar criteria. Various challenges to convey their stories, subjects responded in ways suggesting that a good story was one that rang true. Time and again, in support groups for caregivers of people with Alzheimer's and in interviews with family members and significant others, participants referred to this criterion. For example, following frightening stories of encounters with spouses who for the first time failed to recognize their husbands or wives, it was not uncommon for other group participants to respond with comments such as, "Yes, that's exactly the way it was for me," "That's telling it like it is," and "That's what it is in a nutshell."

A second criterion of the good story centered less on what rang true and more on the importance of a story being engrossing or entertaining. A good story might be engrossing because it rang true, but it also could be engrossing because it conveyed caregiving experiences in a captivating way. Fiction might be entertaining and engrossing, and we can enjoy its narratives for that reason alone, even while it might suggest various truths to us in the process. In the Alzheimer's research material, it was not unusual for caregivers to offer hilariously engaging and embellished accounts of "the funny things" that happen in the caregiving process, which often struck a balance with the dire and morose expe-

riences that were often heard. It was a good story, for example, when 70-year-old Martha, a long-time home caregiver for her husband told of the time when her husband, who suffered from dementia, tried to dress himself and put her panties on over his trousers. "What a sight that was," recounted Martha as she embellished the humor, and what an entertaining narrative of the caregiving experience it was for those who listened. In contrast, some told engrossing stories of strange and unexpected turns, uncharacteristically violent, in the otherwise quiet or calm personalities of their family members with dementia, stories that engaged listeners and took them along a different path. These stories poignantly brought to light one of the darker sides of the Alzheimer's experience.

A third criterion related to listeners' need for adequate detail. I myself often responded positively to interviewees' stories that were very good because they were so richly detailed. A one-line response to a question about how a caregiver felt the first time the person in her care failed to recognize her was less satisfying than a variegated account of the thoughts and feelings she experienced in the process. Most participants in the support groups and the interview respondents wished to know more, not less, about what care recipients and caregivers were going through. They wanted to hear varied facets of the experiences they shared in common. It was a way of comparing notes, enabling individuals to put these experiences into perspective. According to this criterion, a good story was one that provided enough information to be useful to the listener as he tried to manage his own affairs in this social world, including managing the fluctuating identities and changes in the life circumstances of himself and the care recipient, and the varied commitments entailed.

A fourth criterion was the mirror opposite of the third, a version of the standard that less is more. Stories were not only judged positively for how usefully detailed they were, but also were judged negatively if they communicated excessive detail. My own response to interviewees was similar. There were times, for instance, when interviewees went on seemingly endlessly about matters such as lucid moments or clues to the

onset of the disease, well beyond what seemed to me to be useful to anyone. In the support groups, caregivers responded to stories that had excruciating or repetitive detail with such blatant remarks as "My God, will she ever end," "We've heard that umpteen times already," and "Who can take in all that stuff?" Information that was adequate, not exhaustive, was what they wanted. Stories that were too long led to calls for endings, or simply for the story to stop—with no conclusions at all.

THE GOOD STORY IN PRACTICE

While a story that rings true is apparently a good one, there is still the issue of what the truth is believed to be in particular circumstances. If an engrossing account is appreciated, what in the here-and-now is considered to be engrossing? And what sort of detail do we need in specific situations where detail is offered or requested? These kinds of practical questions do not undermine the importance of the good-story criteria described so much as they turn us to the specific times and places in which stories are evaluated. These are the settings that, in their separate ways, take the criteria in particular directions. A caregiving story that, say, rings true in one setting may not ring true in another. The criterion still applies, but the specific locale adds a substantive twist to practical considerations of the matter.

The settings that take narrative criteria in particular directions have been described as "discursive environments" (see Holstein and Gubrium, 2000; Gubrium and Holstein, 2001). The term highlights the importance of time and place for evaluating narratives. At certain times and places (environments), particular kinds of caregiving stories seem to ring true, while at other times and places, the same stories—as otherwise truthful, engaging, and appropriately detailed as they might once have been—are figured to be inauthentic or not "the real story." The settings in which we engage in storytelling about matters such as lucid moments or frightening encounters with the unfamiliar are important and influence the way a story is received because what is concretely said about these experiences in some settings is not necessarily valued in the same way as in others.

The broader point is that the study of storytelling, and the related documentation of good stories, does well to consider that criteria and other standards operate in practice, that the good story cannot be figured separate from the circumstances in which it is told and heard.

The Alzheimer's disease support groups provide an example. Over time, the support groups in which I conducted participant observation struck me as being different in the way group members offered and responded to accounts of their caregiving experience. If I learned that participants in all of the groups evaluated accounts in terms of the criteria discussed earlier—the good story, for example, being the one that rang the truest or was the most engaging—I also recognized that what was true or engaging in one group was not necessarily the same as it was in another one. I soon figured that these groups could be thought of as distinct discursive environments for storytelling, applying the criteria in particular ways. While the groups were not completely distinct, there were some groups that preferred a more formulaic rendition of the caregiving experience. Other groups seemed to value no one form over another. In the former groups, what rang true, what was articulated in detail, and what was responded to as engaging were stories that followed a more formal, script-like presentation of particular stages of what one went through as a caregiver, along with more formal lessons about what was happening to the care recipient—the stages he or she was going through. In the latter groups, participants were generally satisfied to simply compare and contrast experiences, learning from each other about themselves and about their afflicted family members. Storytelling in these groups unfolded in terms of what social psychologists call social comparison processes, where there are no overarching models of meaning-making, but, rather, where meaning develops in the course of social interaction, in relation to the particular experiences conveyed.

The two types of groups, then, contrasted as discursive environments. The good story presented and heard in one type was not the good story presented and heard in the other, even while the criteria discussed earlier applied equally. What rang true in one type of group,

for instance, was not the same as what rang true in the other type.

CONCLUSION

The answer to the question "What is a good story?" needs to be figured in relation to narrative practice (Gubrium and Holstein, 1998). The good story cannot be evaluated solely in relation to criteria such as truthfulness and amount of detail. Nor can it be viewed as unfolding along particular lines, as the self-help literature suggests. In practice, the story is not simply told, but relates to its circumstances. Issues such as what stories are for, what they do for people, and preferred ways of conveying experience are always at stake. Narrative not only communicates, but, for better or worse, has moral consequences—preferences and actions related to who and what we are and could be, as well as what we owe to ourselves and to each other. Stories are not presented and heard over and above everyday life, but within it, organizing our responses in the process.

Understanding narrative practice places limits on what guidebooks, counselors, and the self-help industry can do for us. It opens to view the endless possibilities for good stories and the diverse moral contours of the experiences conveyed through them. In their own ways, caregivers know this and make good on it. I recall a remark a caregiver made one night in a comparatively less formulaic support group I was attending. Commenting on the support group she'd been going to across town and comparing it to the group she now attended, she asserted, "I just can't bear to go there [across town] anymore. All I heard there was stage one, stage two, and take the next step. Here, the stories you

hear sound more like what I'm going through. I learn more from that and it makes me feel better." Narrative control clearly has its limits in a world in which there are recognizable differences in the ways the good story can be conveyed and acted upon. ☪

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