

MEANING-MAKING AND CHRONIC ILLNESS: COGNITIVE AND NARRATIVE APPROACHES

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Abstract: In this paper, we review literature regarding meaning-making and chronic illness from two different perspectives: the cognitive perspective and the narrative. In the first section, we briefly discuss meaning and its connection to serious illness. In the second section, we discuss meaning and chronic illness from the cognitive perspective. First, we examine the ways in which meaning-making has been conceptualized in the coping literature. Second, we present descriptive findings on the forms meaning-making takes when coping with a chronic illness. Third, we review the sociodemographic and medical correlates of meaning-making in the context of a chronic illness. Fourth, we present findings regarding the relationship between meaning-making and adaptation. In the third section, we discuss meaning and chronic illness from the narrative perspective. More specifically, we discuss issues relating to the temporal dimension in illness narratives, the biographical disruption and identity reconstruction associated with a chronic illness, the moral dimension of the illness experience and, finally, the role of social context on illness narratives. In the last section, we discuss the similarities and differences between the two approaches and identify areas where each could be fruitfully informed by the other.

Key words: Coping, Chronic illness, Illness narratives, Meaning-making.

INTRODUCTION

In recent years, there has been a growing interest in understanding the role of meaning in the efforts of individuals to deal with serious negative life events, such as a chronic illness (Crossley, 2000a; Frank, 1995; Kleinman, 1988; Park & Folkman, 1997; Tedeschi, Park, & Calhoun, 1998; Tennen & Affleck, 1999). This literature argues that illness is fundamentally se-

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mantic, that is, it is imbued with meaning, and that the construction of meaning is central to the illness experience. In this paper, we review the literature regarding meaning-making and chronic illness from the cognitive and narrative perspectives. These approaches study the process of meaning-making in different but compatible and, as we will argue, complementary ways.

The view that humans are driven by a psychological need to create a sense of purpose and meaning in their lives has been cogently theorized by existentialism; however, several contemporary approaches—such as constructivism, social constructionism, and narrative psychology—also converge on the fundamental premise of existential psychology that meaning is central in human life (e.g., Barrett, 1967; Cain, 2002; Frankl, 1946; Yalom, 1980). Moreover, it has been argued that the need for meaning has been intensified in contemporary western societies as the influence of religion¹, which until recently was the main source of meaning in the western world, has waned (Barrett, 1967).

In contemporary theorizing, meaning has been defined as the «shared mental representations of possible relationships among things, events, and relationships» (Baumeister, 1991, p. 15). In other words, meaning is what connects things and gives cohesion to our lives. Baumeister (1991) proposes that meaning must satisfy specific needs. Several overlapping categorical systems have been proposed to classify these needs, with most theoreticians agreeing that there is a need for purpose (goals), for a value system, for a belief in a fair, just and benevolent world, for self-worth, and for efficacy, that is, the need for life to be controllable and predictable (Baumeister, 1991; Janoff-Bulman, 1992; Park & Folkman, 1997). A person that has satisfied all of these needs will probably feel that his or her life has meaning and making sense of life will not be a problem (Baumeister, 1991). However, if one need is not satisfied, then that person will have to rethink and even re-structure his or her life until all needs are satisfied.

In general, suffering is purported to be characterized by a loss or lack of meaning (Baumeister, 1991), as it undermines one's broad assumptions about the nature of the world (Janoff-Bulman, 1992). However, as many ex-

1. Religion and meaning are intricately interconnected, in that religious beliefs provide a cosmic meaning, the belief that one's life is part of a larger, coherent pattern (Yalom, 1980). Specifically, religious beliefs provide purpose, values, a belief in a fair, just and benevolent world, self-worth, and efficacy. Because of that conceptual overlap, religion is included only in the discussion of empirical studies where spiritual beliefs were explicitly addressed.

istential theoreticians and clinicians have noted, the human drive to create meaning plays a vital role in our capacity to transcend even the most horrifying of experiences and to grow psychologically through them (Frankl, 1946; Yalom, 1980). Illness, in particular, not only disrupts the fabric of daily life but also demands a redefinition of the self, for example with respect to one's sense of vulnerability or to highly valued personal goals (Bury, 2001). Thus, illness stimulates the need for meaning and responses to illness often entail an effort to find meaning, in terms of making sense of the illness itself and of restoring the sense of meaningfulness that is threatened by it (Baumeister, 1991; Janoff-Bulman, 1992). It is worth noting, however, that meaning-making is not a solely individual affair, but it is also a social process, both in the sense of a person's sharing their experience in the various social contexts of his/ her life and in the sense that deeply held personal meanings are constructed in a sociocultural context, with powerful presuppositions regarding life, self and morality (Frank, 1995).

In the next section, we present conceptualizations of meaning-making and findings regarding its relationship to adaptation from the cognitive perspective. Then, we describe findings regarding meaning-making and chronic illness from the narrative perspective. Lastly, we attempt to identify important issues that are raised from both traditions, their differences, and the implications of these similarities and differences regarding the understanding of meaning-making and chronic illness.

COGNITIVE APPROACHES

In the coping literature, meaning-making has been given a variety of conceptual and operational definitions. Examples of these are personal significance of the event, attributions regarding the cause of the event, positive reappraisal, benefit-finding, posttraumatic growth, and stating the extent to which one has made sense of or found meaning in the event (Calhoun, Cann, Tedeschi, & McMillan, 2000; Park & Folkman, 1997; Sears, Stanton, & Danoff-Burg, 2003; Tedeschi et al., 1998; Thompson, 1991; Thompson & Janigian, 1988). In part, these definitions reflect whether meaning is conceived as appraisal, coping or outcome. Appraised meaning, which has also been called implicit meaning (Thompson & Janigian, 1988), refers to the initial assessment of the personal significance of a specific event (Park & Folkman, 1997). It is a function of the characteristics

of the event combined with the person's beliefs, commitments and goals, and perceived options regarding what can be done about the situation (Park & Folkman, 1997). Although implicit meaning is not the same as meaning-making, they are related. An event of no great significance to the person will be assimilated more easily to the existing meaning structures and assumptions regarding the world. An event of great negative significance for the person, such as a chronic illness, is more likely to challenge these assumptions (Thompson & Janigian, 1988).

Attributions regarding the cause of the event –such as “why did this event happen?”, “why did it happen to me?”, and “who is responsible for it?”– have also been associated with the meaning of a negative life event (Park & Folkman, 1997; Thompson, 1991; Thompson & Janigian, 1988). However, they are not considered to be identical because, although the absence of an attribution results in a loss of meaning, having an explanation for the event does not necessarily mean that one has found meaning (Thompson & Janigian, 1988). An example of the latter would be an attribution that challenges existing assumptions and life meaning.

Three terms commonly employed in the relevant literature are positive reappraisal, benefit-finding, and posttraumatic growth; these are related because of their shared emphasis on positive meaning. Positive reappraisal, which has also been called benefit-reminding, has been described as the intentional and repeated use of benefit-related information and is regarded as a coping strategy (Sears et al., 2003). This is in contrast to benefit-finding that has been described as the identification of benefit from adversity and as a natural, effortless process in which most people facing a chronic illness engage (Sears et al., 2003).

Posttraumatic growth has been described as the “experience of significant positive change arising from the struggle with a major life crisis” (Calhoun et al., 2000). Tedeschi et al. (1998) emphasize that the term posttraumatic growth refers to a level of adaptation higher than that before the individual encountered the crisis and that it reflects genuine positive changes and not just perceived changes. In contrast, positive reappraisal and benefit-finding may reflect a selective evaluation of the situation and a cognitive construction designed to protect existing life meaning. Studies have found a positive relationship between positive reappraisal, benefit-finding, and posttraumatic growth, indicating that the three concepts are related, although they have different predictors, suggesting that they are distinct (Sears et al., 2003; Widows, Jacobsen, Booth-Jones, & Fields, 2005).

According to Park and Folkman (1997), a major task in the management of meaning is to reduce the incongruence between the appraised meaning of a situation or an event and the person's pre-existing global meaning, namely a person's enduring beliefs and valued goals. People continue to process the information until either the meaning of the situation or the global beliefs and goals change, so that they reach congruence. Particularly in circumstances that are not amenable to problem solving and thus threaten self-efficacy, the stressful impact of the problem may be buffered by responses that control the meaning of the problem. Searching for and finding some reason why an event occurred and who or what is responsible for its occurrence can help people make sense of their unfortunate and traumatic experiences. However, when the consequences of an unchangeable negative event are so severe that they cannot be moderated sufficiently through cognitive coping processes, people are left trying to understand how the event, and its consequences, fit their previous views of the world (Park & Folkman, 1997). Sometimes, they do that by revising their beliefs and goals, that is, by changing global meaning. For example, a serious illness may mean that several life goals are threatened and a person can move on either by finding appropriate substitutes or by abandoning them altogether. In such a situation, goal substitution itself may constitute the subjective experience of meaning-making.

Meaning is made to the extent that the newly reappraised meaning of an event and the person's global beliefs and goals are congruent. Therefore, for persons who face a serious life problem, meaning-making is described as both a process and an outcome, in that the person is involved in an effort to search for meaning (coping) and in order for the person to reach a state of equilibrium the need for meaning must have been satisfied (outcome). If a mismatch persists, then the person will continue to try to make meaning in order to reduce the incongruence between the meaning of the situation and global meaning. If this process fails entirely, then the person may engage in a process of rumination and ultimately experience distress. However, meaning-making itself may lead to negative life meaning. For example, a chronic illness may lead one to feel that he/she is more vulnerable and less in control, that the future is less certain, and that the world is unfair and unjust. Thus, meaning-making may lead to a new, more negative identity. This form of meaning-making has been largely ignored by the coping literature.

Forms of meaning-making

In this section, we review studies that have used open-ended questions and structured instruments to examine purported changes in patients' lives that reflect a change in meaning as a result of a chronic illness.

In one such study (Mohr et al., 1999), patients with multiple sclerosis (MS) were asked to describe how MS has changed them as persons and their relationships. Three factors were formed from the responses: The first was described as demoralization and included statements such as "MS has made me more cynical" and "MS has made me more uncertain about the future". The second factor was described as benefit-finding and included items such as "MS has made me appreciate life more." The last factor was labeled as deterioration in relationships and included items such as "I worry I am not a good mate because of my MS." These three factors were also found with cancer and lupus patients (Katz, Flasher, Cacciapaglia, & Nelson, 2001). Benefit-finding was reported more frequently than negative changes. Among the most common benefits the patients described were a deeper appreciation for life, more compassion for others, feeling more open about the expression of feelings, and becoming more introspective and spiritual.

In a similar study, Updegraff, Taylor, Kemeny, and Wyatt (2002) asked women of low SES who were HIV positive to describe how their seropositivity changed their view of themselves, of their body, their relations with their partner and others, and their life priorities. The women reported both positive and negative changes and the two were negatively related, suggesting that they are not independent. Overall, women reported more positive changes than negative, although this difference was not consistent across all areas of their lives where changes were incurred. Specifically, they were more likely to report positive changes in their self-image and in their life priorities and negative changes in romantic relationships, their view of their body and in their relations with others. Positive changes included feeling stronger, wiser, and more understanding. However, they also felt less attractive, more fearful of starting and maintaining a relationship, and distrustful of others.

In contrast, Fife (1994), based on interviews with cancer patients, found changes in self-meaning and in particular mostly negative meaning in the form of loss of control, threats to self-worth and changes in body image. Patients also reported loss of continuity between the past, the present and the future, disruption of life goals and negative changes in personal relation-

ships. Positive changes were also reported in the same areas, such as aspects of self-worth, future goals and personal relationships.

Folkman and her collaborators have published a series of reports based on interviews with HIV seropositive and HIV seronegative caregivers of partners with AIDS (Folkman, 1997; Folkman, Chesney, & Christopher-Richards, 1994). Although the caregivers reported feeling dysphoric, they also sustained a sense of well-being that they attributed to their ability to continue to find positive meaning in their relationship with their partners. Examples of the responses indicated that meaning arose from a deeper appreciation of the relationship, greater sense of self-worth because of newly found strength to cope with the illness of the partner, newly found purpose in caregiving, and new appreciation of life as ordinary daily events take a significant meaning. Also, the participants made spontaneous references to spiritual experiences. The references to spirituality indicated that these beliefs provided a sense of connection to others and a sense of participating in something with a higher purpose. In a question that attempted to address the infusion of ordinary events with meaning, participants answered "yes" in 99.5% of the cases, indicating that people note positive events in the midst of distress. Similar findings have been reported with individuals who have suffered heart attack and stroke (Affleck, Tennen, Croog, & Levine, 1987; Thompson, 1991).

Several studies have used structured questionnaires to assess purported life changes that reflect a positive change in meaning. The most common posttraumatic growth areas reported, using these instruments, were appreciation for life, new priorities, strengthened interpersonal relationships, and an improvement in the ability to express and enjoy oneself (Cordova, Cunningham, Carlson, & Andrykowski, 2001; Widows et al., 2005). Areas least likely to be reported were new opportunities, goals, and interests (Widows et al., 2005). Several studies compared women with breast cancer with those with a benign breast problem or with healthy controls. Women with cancer reported greater recent improvement in their outlook on life relative to the control group but at the same time lower quality of life (Andrykowski et al., 1996). They also reported greater improvement in their relationship with family, greater love for spouse, spiritual improvement, and greater appreciation for life (Andrykowski et al., 1996; Cordova et al., 2001). Tomich and Helgeson (2002) also found that breast cancer survivors were more likely to report benefit from their experience than healthy controls but these women were also more likely to view the world as random.

In conclusion, these studies suggest that meaning-making, both positive and negative, is part of the process of coping with a chronic illness. In addition, meaning-making seems to be involved in several aspects of the patients' lives, such as self-worth, values, goals, efficacy, and perceptions of the world.

Correlates of meaning-making

In an effort to understand the phenomenon of meaning-making in the context of chronic illness, studies have examined its relation to several variables, including demographics and medical variables. Studies that have examined demographic variables as predictors of positive meaning have found that younger age (Bellizzi, 2003; Bellizzi & Blank, 2006; Fortune, Richards, Griffiths, & Main, 2005; Lechner et al., 2003; Manne et al., 2004; Thompson, 1991; Widows et al., 2005) and higher education (Bellizzi, 2003; Bellizzi & Blank, 2006; Sears et al., 2003; Updegraff et al., 2002) are related to positive meaning, although some studies have found no relationship (Katz et al., 2001; Lechner et al., 2003; Lichtman, Taylor, & Wood, 1987; Pakenham, 2005; Tomich & Helgeson, 2004; Vickberg, Bovbjerg, DuHamel, Currie, & Redd, 2000; Vickberg et al., 2001) or even the opposite relationship (Carver & Antoni, 2004; Tomich & Helgeson, 2002; Widows et al., 2005). Caucasian women were less likely than Hispanic and African-American women to perceive personal growth from their breast cancer experience and more likely to view the world as random (Tomich & Helgeson, 2002, 2004). Regarding gender, income, marital status, and employment status some studies have found no relationship (Pakenham, 2005; Vickberg, Bovbjerg, et al., 2000; Vickberg, DuHamel, et al., 2001; Widows et al., 2005), whereas others have found that income, employment, and marital status are positively related to positive meaning (Bellizzi, 2003; Bellizzi & Blank, 2006; Cordova et al., 2001; Mohr et al., 1999; Updegraff et al., 2002).

As Updegraff et al. (2002) point out, these studies suggest that positive meaning-making is, in part at least, a socioeconomic phenomenon and their findings are consistent with Hobfoll's (1989) conservation of resources theory that proposes that perceptions of stress-related growth are strongly influenced by a person's pre-existing resources. Indeed, the relationship between income, education, and positive meaning-making is robust even when potential confounding variables, such as ethnic group, are accounted for

(Updegraff et al., 2002). However, at least one study found that women from low SES (combined education, income, and occupation) were more likely to perceive benefits (Tomich & Helgeson, 2004) and thus this issue remains open. Regarding negative meaning, married, educated, and employed patients with cancer, lupus or MS appear to be less demoralized and/or experience less deterioration in their relationships (Katz et al., 2001; Mohr et al., 1999). Social support has also been related to positive meaning and negatively related to negative meaning (McCausland & Pakenham, 2003; Sheikh, 2004; Updegraff et al., 2002). However, other studies have found no relationship between social support and meaning (Cordova et al., 2001; Widows et al., 2005). Finally, women who had a history of trauma were more likely to report negative meaning as a result of an illness (Updegraff et al., 2002).

Regarding disease variables and positive meaning, some studies have found no relationship (Cordova et al., 2001; Widows et al., 2005), some studies that have looked at patients with only stage I and II cancer have found that the worse the initial diagnosis, the higher the positive meaning (Bellizzi & Blank, 2006; Carver & Antoni, 2004; Tomich & Helgeson, 2004), whereas others have found a curvilinear relationship (Lechner et al., 2003). Specifically with cancer patients, stage II patients reported more benefit-finding than patients at stage I and IV (Lechner et al., 2003). Lechner et al. (2003) propose that patients with stage IV cancer may feel so threatened that they cannot cognitively process the consequences of the illness and therefore a search for meaning is either not undertaken or is unsuccessful in reconciling the negative sequelae of the disease with their existing life meanings. According to Lechner et al. (2003), it is uncertainty about the future that leads into the greatest potential for benefit-finding. Regarding negative meaning, demoralization was found to be related to level of disability, both physical and cognitive (Mohr et al., 1999).

One would expect that the more serious the perceived threat regarding the illness, the more likely that existing life meanings and world views will be challenged. Indeed, there is some evidence that the more severe the appraisals of the stressfulness of the illness, the higher the reports of positive meaning, even when controlling for objective measures of threat (Bellizzi, 2003; Cordova et al., 2001; Lechner et al., 2003; Park, Cohen, & Murch, 1996; Sears et al., 2003; Widows et al., 2005). However, others have found no such relationship (McCausland & Pakenham, 2003; Pakenham, 2005).

Finally, time since diagnosis is an important issue, not only because meaning-making may be a process that takes time but also because the different phases of an illness pose different challenges to individuals. Indeed, a positive relationship between time since diagnosis and positive meaning has been found (Cordova et al., 2001; Pakenham, 2005; Sears et al., 2003) and in one study where the same women with breast cancer were followed over time, positive meaning increased over time (Manne et al., 2004). However, Lechner et al. (2003) and Bellizzi (2003) found no such relationship. Overall, sociodemographic, cultural, and medical variables seem to be relevant in the process of meaning-making.

Meaning-making and adaptation

Physical health. To our knowledge, the few studies that have explored directly the relationship between meaning-making and actual physical health (Affleck et al., 1987; Bower, Kemeny, Taylor, & Fahey, 1998; Cruess et al., 2000; Milam, 2003) have found a positive relationship. For example, Bower et al. (1998) interviewed HIV seropositive men who were grieving the loss of their partner and followed them over a two year period. Of them, 65% percent were involved in cognitive processing, that is, in deliberate, effortful or long-lasting thinking about the death of the partner, while 40% of them ended up discovering meaning in the experience (a major shift in values, priorities, or perspectives). Meaning was related to immune system indices (indicating better immune functioning) and lower mortality rates. Similar findings regarding immune system indices were reported by Milam (2003). The relationship between benefit-finding, cortisol levels and the effect of a stress management intervention were examined in a group of women with breast cancer (Cruess et al., 2000). The intervention had an impact on cortisol levels and this effect was mediated by benefit-finding, where the higher the benefit-finding, the greater the reduction in cortisol levels, even after controlling for baseline cortisol levels.

Finally, the relationship between causal attributions, benefit-finding, and long-term physical health was examined among a group of men who had just suffered their first heart attack. Affleck et al. (1987) found not only that the failure to perceive benefits and the tendency to blame others were associated with a higher incidence of reinfraction over time, but also that men who survived subsequent heart attacks perceived more benefits and made more causal attributions of any kind.

Overall, although few studies of this kind have been conducted, there is strong evidence that meaning-making is related to physical health.

Well-being. Both cross-sectional and prospective studies have confirmed the relationship between positive meaning-making and well-being, such as mental health, hope, positive mood and perceived physical health (Carver & Antoni, 2004; McCausland & Pakenham, 2003; Sears et al., 2003; Tennen & Affleck, 1999; Tomich & Helgeson, 2002; Vickberg et al., 2001). The Sears et al. (2003) study showed that the relationship between meaning-making and positive mood may not be simple. Specifically, positive reappraisal predicted positive mood, but only for women with low or medium levels of positive mood at baseline. Contradictory findings also exist. At least one study found no relationship between positive meaning-making and well-being (Cordova et al., 2001) and in another study, breast cancer survivors, who were still searching for meaning five years post-diagnosis, had poor mental functioning and less positive affect, indicating that timing may be very important and that searching for meaning years after the diagnosis may be indicative of an unsuccessful attempt to assimilate the event into existing world views (Tomich & Helgeson, 2002). Finally, Tomich and Helgeson (2004) found that benefit-finding predicted worse mental functioning six months later, particularly so for women with a more severe diagnosis.

Although the findings are not unequivocal, there is evidence, from both cross-sectional and prospective studies, that well-being is related to positive meaning-making. In addition, at least two studies have shown that negative meaning-making is negatively related to well-being (Katz et al., 2001; Updefraff et al., 2002).

Distress. The relationship between positive meaning and distress, which in this section includes perceived pain and perceived functional disability, has not been elucidated. Prospective and cross-sectional studies show a negative relationship between positive meaning and distress (Carver & Antoni, 2004; Danoff-Burg & Revenson, 2005; Katz et al., 2001; McCausland & Pakenham, 2003; Milam, 2003; Vickberg et al., 2000; Vickberg et al., 2001), although the opposite (Mohr et al., 1999; Tomich & Helgeson, 2002, 2004), and no relationship have also been found (Cordova et al., 2001; Widows et al., 2005). The inconsistent findings indicate that the relationship is complex and may be a function of many variables.

For example, although benefit-finding was negatively related to distress among patients with cancer and lupus (Carver & Antoni, 2004; Katz et al., 2001), it was positively related to distress among MS patients (Mohr et al.,

1999). Another study with MS patients found a more complex relationship between posttraumatic growth and distress, in that posttraumatic growth was negatively related to distress only for patients that experienced high stress related to their problem (Pakenham, 2005). These inconsistent findings raise the possibility that the type of chronic illness may also play a role in the relationship between meaning-making and distress.

In a study with cancer survivors, aspects of positive meaning, such as the belief in a just world, that one can control one's environment and that there is a purpose in one's life, were negatively related to distress, but benefit-finding was unrelated to distress (Tomich & Helgeson, 2002). The differential findings regarding aspects of meaning raise the issue of whether the changes reported by benefit-finding are real. In the same study, cancer survivors, who were still searching for meaning five years post-diagnosis, experienced more distress (Tomich & Helgeson, 2002). Searching for meaning five years post-diagnosis may be indicative of an unsuccessful attempt to match the meaning for the problem with global views, and may eventually lead to a ruminative process and thus to distress (Tomich & Helgeson, 2002). Tomich and Helgeson (2004) also found that the positive relationship between benefit-finding and distress is moderated by severity of disease. Specifically, in a study with breast cancer patients, benefit-finding four months post-diagnosis was positively related to distress six months later, but mostly for women with a severe diagnosis. In contrast, Carver and Antoni (2004) found a negative relationship between distress and benefit-finding, using very similar instruments. However, there are important differences between the two studies. For example, the follow-up range for the Carver and Antoni (2004) study was four to seven years and as mentioned earlier, time is an important variable to consider in the study of meaning-making.

The reverse relationship also has been examined, that is, whether distress predicts meaning-making. In a study with cancer patients, it was found that although concurrent and prior psychological distress did not predict posttraumatic growth, retrospective ratings of past distress were positively related to concurrent growth (Widows et al., 2005). The authors conclude that growth is related to perceived reduction in distress and not actual reduction, and thus the changes in perspective reported probably reflect a denigration of the past and not actual changes implemented as a result of the illness (Widows et al., 2005). This explanation is further supported by the fact that posttraumatic growth in this study was also related to avoidant coping. However, in a study where women with breast

cancer were asked to rate their level of quality of life prior to their illness, their ratings did not differ from those of women with a benign breast cancer (Andrykowski et al., 1996). This finding disputes the assertion that meaning-making really reflects an effort to devalue the past.

The relationship between attributions and distress has also been explored. It has been found that asking the question “why me?” and assuming that somebody else is responsible for one’s misfortune has been associated with distress but the results are equivocal regarding attributions to heredity, luck, stress, and the self (Michela & Wood, 1986; Silver & Wortman, 1980; Taylor, Lichtman, & Wood, 1984). Finally, the few studies that have explored the relationship between negative meaning and distress have found a positive relationship (Katz et al., 2001; Mohr et al., 1999; Tomich & Helgeson, 2002; Updegraff et al., 2002).

Overall, there is some evidence that positive meaning-making is negatively related to distress and strong evidence that negative meaning-making is positively related to distress. The inconsistent findings regarding positive meaning may be the result of the different timeframes of the various studies, of the type of the disease, and of the method used to assess meaning. Indeed, it has been proposed that distress motivates individuals to engage in the process of meaning-making and thus a positive relationship would be expected at the first stages of the process. Reports of early meaning-making may then reflect either illusory changes in perspectives or pressure to be positive, whereas later reports may reflect more meaningful cognitive and emotional changes, also accompanied by behavioral changes. For some researchers this issue (real or illusory) is irrelevant because it is not the pragmatic value of the meanings that is of importance, but rather having an explanation for the illness (Baumeister, 1991). The findings presented in this section suggest that whether reports of meaning-making reflect illusory or real changes may be an important issue for adaptation. Finally, reports of struggling to find meaning years after the diagnosis may be indicative of a ruminative process and thus a positive relationship to distress would be expected.

NARRATIVE APPROACHES

In recent years, the notion of narrative has acquired increasing importance in psychology, and researchers from diverse backgrounds employ the notion

of the narrative study of lives as an interdisciplinary attempt to understand personal and social life (e.g., Bruner, 1986; McAdams & Janis, 2004; Polkinghorne, 1988; Sarbin, 1986). This “interpretative turn” has fuelled the growth of a significant body of literature on the role of narrative in understanding the experience and the meaning of serious illness. Anthropological and ethnographic research seems to suggest that storytelling in response to illness is ubiquitous (e.g., Early, 1982; Good et al., 1994) and the narrative reconstruction of a biography disrupted by illness seems to be a shared human need (Williams, 1984).

A comprehensive review of narrative research on chronic illness is beyond the scope of this paper; we aim, however, to present the main issues raised by this body of research as well as some of its major findings with respect to meaning-making in chronic illness. The studies have been organized along four thematic axes that focus on the following issues: (a) the temporal dimension of illness narratives, (b) biographical disruption and identity reconstruction following a serious illness, (c) the moral dimension of illness experience, and (d) the role of social context on meaning production.

Illness experience, temporality, and narrative

Time is a fundamental aspect of human existence and central to our understanding of narrative; more specifically, temporality is implicated in illness narratives in at least two ways. Narrative research provides a means of studying the evolution of the meanings of illness over time and, secondly, time is manifest in illness narratives in relation to a shift in the usual time orientation individuals have towards the future, which is fundamentally challenged by serious illness.

In the framework of narrative psychology, the meaning of illness is seen as an evolving process, influenced by the illness course and various events in the person’s life. In this way, meaning reconstruction following a serious illness is not something that is accomplished once and for all, but reflects a dynamic, evolving and non-linear process. For example, with respect to the meaning of cancer for western populations, research has suggested that its meaning changes over time; initially cancer is seen as a threat to self-esteem, self-image and one’s sense of control, implying sickness and death; once it is realized that death is not imminent, cancer often becomes an obstacle to normality and sometimes a turning point in life that facilitates re-examination of goals,

personal growth and transformation (Fife, 1994; Lam & Fielding, 2003; Luker, Beaver, Leinster, & Owens, 1996; Pelusi, 1997; Utley, 1999).

In a study that examined the changing meaning of illness over time in a cultural context, Little, Jordens, Paul, Montgomery, and Philipson (1998) suggested that a major category in the experience of serious illness is that of "liminality", an enduring existential state that reflects the implications and limitations of embodiment. Drawing from interviews with patients suffering from cancer, Little et al. (1998) suggest that individuals utilize three interdependent and reflexively reinforcing themes in their illness narratives, which together constitute "liminality". The first theme is "cancer patientness". In the initial stages of illness this entails the immediate impact of the diagnosis, which involves issues such as confrontation with mortality, feelings of shock, confusion, disbelief, bewilderment, and perhaps relief at the end of uncertainty, a sense of urgency to act, and tensions over surrendering or maintaining control regarding medical decisions. Later, "cancer patientness" refers to the persistent identification as a cancer patient, irrespective of the state of health in purely biomedical terms.

The second theme is "communicative alienation". Early in the illness this mainly relates to the recognition that others can never really share the horror of the diagnosis and its treatments, whereas later it reflects a state of alienation from social familiars as a result of being a cancer patient.

Finally, "boundedness" refers to the various ways in which the world contracts for the patient, in the sense that s/he experiences limitations to space, available time and empowerment, ability and agency. Early in the illness, boundedness is expressed in terms of limits in time and space, of surrendering social and working roles and of loss of empowerment, all of which are usually represented as necessary compliance with the medical system. Later in the illness, boundedness is mostly expressed in terms of existential constraints, uncertainty about the future, constraints on choice and empowerment, and awareness of mortality. Moreover, it is worth noting that these challenges facing individuals are specific to contemporary western culture and ideology regarding health. There is some evidence that, in earlier times, illness was considered part of the irregular, unpredictable life trajectory, a feature of earthly experience to be endured with the help of tradition, family, social circles, and religion (Giddens, 1991). The so called "era of biomedicine" introduced a new paradigm of illness, as an *abnormality* in the life trajectory; in this framework illness intrudes taking people out of their "proper" sphere, and passes responsibility to another agency, medicine.

Moreover, the supporting mechanisms of earlier times are largely not available to a person falling seriously ill in late modern cultures, and this gap is partially filled by the “psy-professions”.

As already mentioned, the second way in which temporality is implicated in illness narratives relates to “lived time”, as the diagnosis of a life-threatening illness can shatter the assumption of the future of our existence; as a consequence, our whole conception of ourselves, our life and our world is likely to undergo radical changes (Crossley, 2000b). This is a process which Frank (1995) has described as “narrative wreckage”. For example, in her study with HIV-positive individuals, Davies (1997) suggested that one of the most difficult aspects of living with the illness relates to the uncertainty regarding the future, which reflects the dilemmatic meanings surrounding AIDS regarding its status as a terminal illness. Many of the narratives manifest the difficulty of maintaining two conflicting life orientations: an orientation towards death that entails a closing off from the future and an orientation towards life that involves an opening and expanding of future horizons. People were shown to deal with this conflict in three basic ways; most begin to live with a “philosophy of the present”, focusing on the moment and describing a new appreciation of the value of one’s life, others continue to “live in the future”, striving to minimize the effects of illness on their life, whilst others still, unable to compensate for the loss of the routine understanding of themselves, live in “the empty present” clinging to the present in rigid and limiting ways or focusing almost exclusively on the past. Moreover, with the exception perhaps of life in “the empty present”, which is often described as an anguished and emotionally depleted state, it is difficult to ascertain whether any life-orientation is inherently more health-promoting (Crossley, 1999, 2000a).

The above studies suggest that time is a dimension that needs to be taken into account in studying meaning construction, both in the sense that illness meanings are complex, evolving, dynamic phenomena that change with situational and life contexts, and in the sense that the experience of a serious illness can affect one’s orientation in time.

Identity: Biographical disruption and narrative reconstruction

One of the key assumptions in narrative research on chronic illness relies on the notion that chronic illness disrupts the person’s life and the forms of knowledge underpinning it, a process that has been described as “biographical disruption” (Bury, 1982). Many chronically ill people experience a loss of self,

as valued aspects of identity are compromised or irretrievably lost, often without the development of equally valued new self-concepts (Charmaz, 1983; 1991). In line with this, Williams (1984) has suggested that an important aspect of adaptation to illness relates to a narrative reconstruction of the meaning of one's whole life, and not just the meaning of the illness.

There now exists a growing body of narrative research that examines the consequences of chronic illness on the self and identity as these are reflected in illness narratives (e.g., Carricaburu & Pierret, 1995; Curbow, Sommerfield, Legor, & Sonnega, 1990; Kohler Riessman, 1990; Little, Paul, Jorden, & Sayers, 2002; Orona, 1990; Xuereb & Dunlop, 2003). In one such study, Yoshida (1993), based on narratives of adults with severe traumatic spinal cord injury, proposed that the process of identity reconstruction following serious illness or disability resembles the movement of a pendulum between different identities, moving back and forth between the disabled and non-disabled aspects of the self. This model conceptualizes identity reconstruction as a dynamic, nonlinear, evolving and dual-directional process.

In a similar vein, Mathieson and Stam (1995), based on narratives regarding the identity issues individuals face in the course of cancer, suggested that these can be described in terms of three issues. "Disrupted feelings of fit" refer to the early signals of threats to identity, where patients begin to identify the discrepancies between their former healthy self and their life with the illness. Bodily symptoms occupy a significant role in these narratives, in terms of a body which no longer fits with the healthy body one took for granted, and which signals to others that the person is a "cancer patient". In addition, prolonged contact with institutionalized medicine also affects individuals' identity, as they become part of a social world where they are primarily identified by their disease status. The second issue relates to the process of "renegotiating identity", with respect to two further threats to identity: the stigma of cancer and the subjugation of their personal voice under the authority of the medical discourse. Finally, "biographical work" relates to an awareness of permanent transformation as a result of cancer, typified by a dichotomy between the "old" and the "new" self after cancer, with important effects on identity and social relationships.

The paradigm of biographical disruption has provided a useful theoretical framework for many narrative studies on chronic illness; its dominance, however, has recently been challenged, an argument which also parallels recent work on bereavement (e.g., Neimeyer, 2005). More specifically, Faircloth, Boylstein, Rittman, Young, and Gubrium (2004), drawing from

their research with people suffering from stroke, suggest that assuming that biographical disruption constitutes a necessary reaction to serious illness may gloss over important aspects of the illness experience, resulting in poorly designed interventions. The appropriateness of the notion of biographical disruption for describing the meanings of chronic illness for a person's identity remains to be further explored. One issue which arises from narrative research on identity reconstruction relates to the moral dimension of adaptation to chronic illness, which is discussed in the following section.

Morality. Narratives provide connections regarding events and, as such, they have a moral dimension; morality has been conceptualized in two main ways in the literature on illness narratives, namely in terms of the question of cause as well as in terms of the values, priorities and sense of "good" that people have with respect to aspects of their illness. For example, Williams (1984), drawing on his research with people suffering from rheumatoid arthritis, suggests that the patients' narratives bring to the fore moral considerations which connect family background, the coincidence between symptoms and life events and the particular social contexts in which symptoms occur. In other words, discussions regarding the cause of illness entail a moral dimension, often reflected in considerations regarding blame and culpability.

In a more recent contribution, Williams (1993) locates illness narratives in a cultural framework that increasingly portrays health as a virtuous state. He suggests that, although illness is not seen as "sin", there is often an assumption that it is the result of inappropriate, even "immoral", individual behaviours. More specifically, he identifies three dimensions of "virtue" articulated in illness narratives; the first relates to the concern of many persons not to become a burden, which alludes to the notion that dependency is something to be avoided, a notion reflecting the moral dimension of self-contained individualism (e.g., Sampson, 1993). The second issue relates to threats to the ill person's ability to present oneself as respectable, often expressed in terms of concerns regarding orderliness and cleanliness. The third issue concerns anxieties about falling into debt, which can be interpreted as a reflection of "letting oneself go" or being out of control.

As Bury (2001) maintains, however, the moral qualities of illness narratives are not confined to maintaining "normal appearances" and the "virtuous presentation of the self". In the 1990s a more "self-development" dimension to illness narratives could be detected, especially in the U.S. literature. Patients talk of their illness as a form of disruption which can be turned into

self-discovery and renewal. Frank suggests that in the context of a “remission society” (Frank, 1995), that is, a society in which large numbers of people live with chronic illness, people strive to be “successfully ill”, and illness presents an opportunity for self-development. This form of “postmodern morality” of renewal and change through illness resonates with much of what is theorised about identity in postmodern societies. However, these narratives may be more contradictory than assumed. Consideration of morality in illness narratives leads us to the final issue examined in this review, that is, the social context in which meanings regarding illness are constructed.

The social context of meaning construction

A basic tenet of narrative psychology is that narration is a process that takes place in social interaction, and so illness narratives need to be examined in the context in which they are produced. The notion of context refers to various levels, and will be discussed in terms of the immediate interactional context as well as the broader sociocultural context in which narration takes place. It is worth noting that we only present studies that focus on the patients’ narratives, rather than professionals’ talk or the actual clinical encounter.

The interactional context of meaning production has been examined both in terms of the elicited context of the research interview (e.g., Baruch, 1981; Pinder, 1995; Radley & Billig, 1996) and the institutional context of the medical encounter. For example, Kohler Riessman (1990) focuses on the constitution of a particular self through narration, by analysing an interview of a recently divorced man with severe multiple sclerosis. By examining the structure of his narrative, she highlights how this man manages to project a strong masculine identity, even in the face of behaviour (due to his illness) which violates common sense definitions of masculinity. As a whole, this man’s biographical reconstruction preserves key aspects of his masculinity, in terms of his adequacy as a husband, father and worker; moreover, the marital separation he was undergoing at the time of the interview was constructed as resulting from his disability, and is therefore represented as not to blame.

Regarding the institutional context of medical encounters, one of the main issues examined to date relates to the gradual introduction of the medical discourse in personal illness narratives (e.g., Ashing, Padilla, Tejero, & Kagawa-Singer, 2003; Bury, 1982; Charmaz, 1983; Crossley, 2003; Farmer, 1994; Kagawa-Singer, 1993). In a similar vein, the clinical encounter has been

recently examined through the notion of “therapeutic emplotment” (Crossley, 2003; Del Vecchio Good, Munakata, Kobayashi, Mattingly, & Good, 1994; Mattingly, 1994), which refers to the process of co-construction, between clinician and patient, of a plot structure influenced by the medical discourse. This perspective highlights the co-constructed nature of meaning-making and the role of institutions, ideology and practices in meaning production.

With regards to studying illness narratives in a wider social context, the relevant literature can be organized along three dimensions: (a) studies which focus on the structural / material characteristics that contextualize the illness narratives, (b) studies that focus on narrative genres or types, and (c) studies that explore the role of cultural models of illness on personal illness narratives.

Structural/material effects. In the field of health psychology a relatively small number of studies have focused on the material and structural context in which meaning-making regarding serious illness takes place (e.g., Anderton, Elfert, & Lai, 1989; Klawiter, 2004). In one such study, Anderson, Blue, and Lau (1991) investigated the complex social, political and economic nexus in which the meaning of diabetes is constructed by women of different ethnic origin. The analysis focuses on both the women’s material circumstances and the ideology underpinning healthcare delivery, and the effects these have on meaning. With respect to the former, issues such as financial and work circumstances, difficulties in communicating one’s needs and the increased gap between physician and patient were explored. With respect to medical ideology, it is suggested that medical encounters occur within the context of the “ideology of self-care”, which assumes that individual effort and inner qualities are responsible for good illness management and thus sidesteps the socio-political, economic and cultural context. As a result, immigrant women often face the paradox of being expected to be responsible for carrying out their own care without having the material resources to do so. Moreover, the material barriers to self-reliance often go unrecognized and behaviour is interpreted as reflecting individual failure in terms of “noncompliance”, “lack of motivation” or “fatalism”; in this way, unequal class relationships and institutional inequities are concealed, health professionals are exempt from scrutinising their practice, and those in need are often excluded from receiving appropriate healthcare.

“Every life story is unique, yet representative of every other life story”: *Narrative genre and narrative type.* Several narrative studies on chronic illness rely on the notions of narrative genre and type. These studies rest on the

assumption that when people construct narratives they do so «within cultural settings which provide specific forms of language, clichés, motifs, references and other elements of linguistic and symbolic repertoires which allow and constrain what is said and how it is expressed» (Bury, 2001, p. 278).

Genre is a concept drawn from literary theory, where it is suggested that all forms of narrative are underpinned by a given number of narrative forms, namely epic/heroic, tragic, comic/ironic, romantic and didactic. With respect to illness narratives, Hawkins (1990) argues that they constitute a separate narrative genre, the “pathography”, which is organized around the notion of regeneration; the typical story relates how the patient has suffered a severe crisis and has come out of it regenerated, as a new person. She further suggests that these narratives have replaced earlier stories of religious conversion and resemble an ancient Christian narrative pattern, where a person lives a life of sin, comes to a realisation of its sinfulness and the experience of regret, and subsequently awakens to a new life.

Narrative types are culturally available storylines that are better conceptualized as “listening paths” rather than rigid structures; they can be defined as «the most general storyline that can be recognised underlying the plot and tensions of particular stories» (Frank, 1995, p. 75). One of the most influential classifications of illness narrative types has been suggested by Frank (1995), who identifies three cancer narratives types: restitution, chaos, and quest narratives. Restitution narratives typically concern movement away from health and back to health, and illness is constructed as transitory. Chaos narratives reveal a storyline organized around the futility, vulnerability and impotence of the sufferer and in terms of structure they typically lack a specific sequence of timings and experience. Quest narratives show that illness can be considered a challenge functioning as an impetus for change. They may be considered therapeutic but are also potentially limiting in as much as they present life «too clean and the transformation too complete, and they implicitly deprecate those who fail to rise out of their own ashes» (Frank, 1995, p. 135; see also Crossley, 2000a; Thomas-McLean, 2004). Another influential typology relies on the temporal aspect of narrative and entails stable, progressive and regressive narratives (e.g., Murray, 2003; Robinson, 1990).

The usefulness of narratives typologies in studying illness experience is manifold; it is a type of analysis which is accessible to several listeners, including ill individuals, medical staff, and social scientists. Honouring narratives, through studying their structure, may enhance health care

through helping clinicians develop sensitivity to listening to patients' stories, and to acknowledge non-preferred narrative types, that is, the stories of chaos and wreckage which often go unrecognized in both research and healthcare. Finally, narrative types provide ways to explore the links between (bodily) experience, meaning and culture (Frank, 1995; Thomas-MacLean, 2004).

Cultural models of illness. The final aspect of social context that has been explored, mainly from a medical anthropological perspective, relates to cultural models of illness and their effects on personal illness stories (e.g., Ashing et al., 2003; Farmer, 1994; Garro, 1994; Hunt, 1994; Kagawa-Singer, 1993; Klawiter, 2004; Mathews, Lannin, & Mitchell, 1994).

Good et al. (1994), for example, studied the representation of illness in the narratives of patients with epilepsy in Turkey, with a broader aim to explore the role of culture in the observed under-use of anticonvulsant medication. The available cultural model of epilepsy that was commonly described as "fainting", invoked different explanatory models involving the evil eye and jinns, childhood fevers and injuries and dramatic stories about the person experiencing a "fright" or grief over a major loss, as well as biomedical explanations. The participants' narratives employed these diverse explanatory models in seemingly contradictory ways. Focusing on the narrative structure of the illness accounts, the authors suggest that illness narratives function powerfully in the "subjunctive mode", that is, they transform certainties into possibilities, given the strong commitment by patients and their families to maintain a world where there are possibilities of healing, even if they require a miracle.

This paper (Good et al., 1994) makes an important observation regarding illness narratives. Illness narratives often embody contradictions and multiplicity and cannot be represented from a single vantage point, as they entail a "network of perspectives". From a positivistic perspective, such narratives may seem contradictory, irrational or incoherent, but a different analytic view emerges from a narrative perspective. In the Good et al. (1994) study, it was suggested that the indeterminacy characterizing the stories is in fact an important narrative strategy that maintains hope for a cure. In some ways this process rests in opposition to the assumption that uncertainty and contradiction in narratives is associated with a "negative" psychological situation; this is a question worth pursuing further (Davies, 1997; Little et al., 1998).

In summarizing the above, illness narratives have gradually acquired an important place in investigating the evolving meanings of chronic illness, within the sociocultural context in which they are produced (e.g., Hydén,

1997; Pierret, 2003). More specifically, in this paper we argue that research on narratives can: (a) illuminate the process of meaning-making, (b) provide insight into the experience of illness, through “thick descriptions” characterized by wealth of detail and depth of personal meaning, (c) highlight the nature of disrupted experience and the process of narrative reconstruction, (d) highlight the performative and functional aspects of narratives, (e) examine the links between experience, meaning, identity, culture and social circumstances, and (f) enhance clinicians’ reflexivity with respect both to our ideologies and practices. On the other hand, it must be recognised that narrative research on chronic illness faces several questions that need further elaboration; one such question relates to authorship, that is, given that narrative research is an interpretative practice, the researchers’ viewpoint needs to be adequately attended to. Moreover, notwithstanding the desire to witness the patients’ story and to limit the often dehumanising effects of a medicalised society, Bury (2001) advises caution in the use of the narrative metaphor, as it can underestimate the mundane and embodied aspects of experience by focusing and elaborating upon “deep structures” or moral virtues.

It is worth noting that the notions of meaning-making, narrative, narrative disruption and reconstruction have recently been fruitfully explored in several areas of theoretical and clinical significance other than illness, namely bereavement (e.g., Currier, Holland, & Neimeyer, 2006; Neimeyer, 2005, 2006), trauma (e.g., Janoff-Bulman, 1992) and psychotherapy (e.g., Angus & McLeod, 2004). For example, recent conceptualizations of grief stress the importance of sense-making in bereavement (e.g., Neimeyer, 2005) and its role in mediating different pathways of mourning (e.g., Currier et al., 2006; Gillies & Neimeyer, 2006). This theoretical and empirical literature lends support to the narrative-constructivist assumption that constructing an understanding of the loss in a way that preserves a sense of autobiographical continuity as well as a sense of intelligibility and hope is central in the process of restoration, following challenging and potentially traumatic life-events (Neimeyer, 2004, 2005), a finding which parallels narrative research on illness experience. Although a fuller discussion of this burgeoning body of work is beyond the scope of this paper, we suggest that cross-fertilization between the various strands of narrative work on self-narrative reconstruction would have many benefits, in terms of further developing the narrative-psychological perspective and narrative analytic methodologies, as well as furthering our understanding of human responses to life-altering experiences and the role of meaning-making in these.

DISCUSSION

This paper examined meaning-making in the context of chronic illness, through reviewing relevant research both from a cognitive and a narrative approach. A general issue that emerged from this review is that, although these two approaches are based on different epistemological and theoretical foundations, and utilize different research methodologies, they raise similar issues and reach similar or complementary conclusions. More specifically, both traditions provide evidence that chronic illness disrupts life meaning. Both identify similar aspects of one's life in which this disruption takes place, including perceptions of the self, values, goals, self-efficacy, relationships, and the perceived benevolence of the world. Furthermore, research from both traditions provides support for the view that suffering stimulates the need for meaning and responses to suffering often involve an effort to restore meaning or a process of narrative reconstruction (Fife, 1994; Folkman et al., 1994; Frank, 1995; Williams, 1984).

Further, both traditions provide evidence that meaning-making following the diagnosis of a chronic illness is an evolving process, although there are also significant differences in the way this issue has been examined by each approach. The issue of time is clearly recognized and taken into account in the narrative approach (e.g., Lam & Fielding, 2003; Little et al., 1998), both in terms of utilizing the notion of narrative in studying the evolution of meaning over time, but also in terms of how one's time orientation shifts as a result of an illness (e.g., Davies, 1997). The cognitive approach, on the other hand, in theoretical discussions presents meaning-making as both a process and an outcome and, in this respect, assumes that any given meaning evolves with time (Park & Folkman, 1997; Tedeschi et al., 1998). However, prospective empirical studies are designed to answer questions regarding the antecedents of meaning-making as an outcome or the causal relationship between meaning-making and adaptation rather than how meaning evolves over time (e.g., Carver & Antoni, 2004; Pakenham, 2005; Tomich & Helgeson, 2004). This conceptualization of meaning-making as an outcome is based on the assumption that it is a linear process with a given end-point. In contrast, the narrative approach conceptualizes meaning-making as a dynamic, evolving and non-linear process (e.g., Mathieson & Stam, 1995; Yoshida, 1993).

A major issue raised by the cognitive perspective is whether the content of meaning is positive or negative and the ramifications of this "valence"

regarding adaptation. In narrative research on illness, this issue is not explicitly discussed and there is only an implicit assumption that meaning may be both “positive” and “negative”. What is considered potentially problematic from this approach is narrative incoherence or “narrative wreckage”; in this case, people seem unable to produce a coherent and integrated self-narrative inclusive of their new life situation. Regarding the role of different reconstructed narratives in adaptation to illness, narrative studies have made few claims, although, in several studies it is implicitly assumed that adaptation relates to accepting the limitations posed by the illness, whilst maintaining a relatively “undamaged” identity (e.g., Crossley, 1998, 1999). The cognitive approach, on the other hand, takes the position that it is possible to define positive and negative meaning and differentiates between the two. It has developed the means to assess each separately, as well as to study the antecedents and consequences of each. As a result, a major question that is raised by the cognitive perspective is whether meaning-making is inherently adaptive. A major strength of the cognitive approach is that it tries to answer this question and although the results are equivocal, there is evidence that positive meaning-making is related to well-being and to physical health, although the results are mixed regarding its relation to distress.

A final issue that is recognized as important in both traditions, albeit conceptualized in different ways, is that of context. For example, the cognitive perspective provides evidence, even though this is equivocal, that ethnicity, education, and income play a role in meaning-making; the research literature on this point to date gives support to Hobfoll’s (1989) proposal that perceptions of stress-related growth are heavily influenced by a person’s preexisting resources. The narrative approach conceptualizes the role of context in meaning-making as operating principally on two levels. The first level relates to the immediate interactional context of narrative production. It is proposed that the stories that patients tell about their illness do not constitute a reflection of some inner mental state, but rather that they have a performative or strategic function within specific social contexts; this function is often conceptualized as constructing a positive identity or refuting possible blame (e.g., Kohler Riessman, 1990; Radley & Billig, 1996). This viewpoint contrasts to the cognitive approach that assumes a representational view on language (meaning reflects the person’s inner mental state), and it reflects the social constructionist leanings of narrative psychology (e.g., Potter & Wetherell, 1987). The second level involves an examination of the links between personal narratives and wider sociocultural

issues. More specifically, structural and material aspects of social context have been examined (e.g., Anderson et al., 1991), as well as the effects of culture in meaning production, both in terms of the narratives types that each culture makes available (e.g., Frank, 1995; Robinson, 1990) and in terms of the cultural models of illness that powerfully shape personal narratives (e.g., Garro, 1994; Good et al., 1994).

Indeed, this last point could be extended beyond patients' narratives to the ideas and values that unwittingly influence the development of theory and research, in other words the theoretical and scientific narratives which are arguably also powerfully influenced by culture. For example, the cognitive approach's preoccupation with the positive or negative valence of meaning-making may reflect the current stress of western culture on positive thinking which has led, in part, to the denigration of negative meaning-making. Even though the relationship between negative meaning and distress has been elucidated (Mohr et al., 1999; Katz et al., 2001; Updegraff et al., 2002), the specific nature of the content of negative meaning may be valuable for understanding the way individuals struggle to adapt to a chronic illness. In this respect, the cognitive approach can be informed by the emphasis given by the narrative approach on the detail and depth of personal meaning and take heed of the narrative perspective's caution that the exclusive emphasis on positive meaning may be limiting because it presents life as «too clean and the transformation too complete, and it implicitly deprecates those who fail to rise out of their own ashes» (Frank, 1995, p. 135).

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