Paul Ricoeur’s theory of interpretation adapted as a method for narrative analysis to capture the existential realities expressed in stories from people living with Multiple Sclerosis

*Abstract*

This paper draws on Paul Ricoeur’s theory of interpretation to highlight aspects of the existential realities that emerge woven within the narratives of people living with Multiple Sclerosis (MS). It aims to give social workers and other professionals involved in inter-disciplinary care insight into the meaning-making process and the existential realities interwoven in accounts of lived experience, thereby validating this aspect of experience. To support this approach it also aims to make explicit the method used and interpretation applied to elicit these features. Ten adults with MS from across the North of England were recruited to tell their story related to the onset of, and adjustment to MS. Two of the narratives are presented, and through these, the method used for interpretation derived from the theory of Paul Ricoeur is demonstrated. What emerge, threaded within the events told in a triptych of past, present and future life envisaged, are glimpses of existential realities that evoke universal recognition such as abandonment, loss, acceptance; solidarity, aloneness, suffering, and finally calm. The paper concludes that, given chronic conditions like MS often predispose existential deliberation, it is important that these dimensions of lived experience are acknowledged in professional encounters that seek to manage the condition and support people living well with it.

*Introduction*

This paper aims to direct the gaze of inter-disciplinary professionals who support people with Multiple Sclerosis (MS) towards an understanding of how people make sense of their lives and of the existential realities in this sense-making. The purpose is to enhance professionals’ existing knowledge of what it is like to live with MS beyond the current focus on treating and managing the condition (NICE 2014), and give participants an opportunity to reclaim their experience of their disease trajectory and the impact it has had on their embodied lives (Frank 1995). It aims to make explicit the method and interpretation applied to achieve this end, in the hope of assisting professionals to both recognise existential realities and become more “meaning-oriented” in their practice (Houston 2010:854). This is particularly important given the dominance of the medical approach to managing and supporting people with MS, an approach that tends to give “pride of place” to the technical side of support (Frank 1995:7) and relies heavily on Disease Modifying Drugs (DMDs) for intervention (NICE 2014). Added to which, the current crisis in welfare provision, with its lack of integrated care across social and medical care, is further diminishing social support that might be expected to complement the medical approach and nurture the lifeworld. These factors are all contributing to a compromised quality of life for people with chronic conditions (King's Fund 2013; Lymbery 2014; Beresford 2014). Also, there is limited or, in the case of social work, non-existent research literature on what it is to live with MS, even though people with the condition require inter-disciplinary support and, often, social care (MS Society 2013).

The diagnosis of a serious chronic condition like MS is usually accompanied by confusion, trauma and grief for the loss of the life trajectory previously-imagined. For a person to adapt they have to begin to assimilate this occurrence and its repercussions. This inevitably leads people to situate the invasion within an autobiographical triptych of past, present and a ‘new-future” life envisaged. This is a process of sense-making at a personal level but one that also reveals patterns, commonalities and discords beyond the personal: a process conceptualised by Bury (1982) as “biographical disruption”, where a person initially struggles with symptoms and diagnosis and is frustrated by a lack of explanations, before re-interpreting life’s meaning and marshalling the energy and resources to adjust to living under new circumstances. This is not just an intellectual process because “we are our body” (Merleau-Ponty 1962: 206) and it is through our body that experience begins and then widens to the world around us. For a person with a condition like MS “the nexus between habitual and actual body are broken” (Moya 2014:2) or at the very least disrupted, leading to failing sensation in limbs and touch, and disturbed balance and sometimes vision, as well as cognitive changes. These unavoidably compromise pre-existing ways of experiencing and knowing the embodied self and the relationship with the world beyond.

*Why narratives?*

“We tell stories because in the last analysis human lives need and merit being narrated” (Ricoeur 1984: 75)

We each need to tell our story or have a “self- narrative” as part of the continual process of constructing and reconstructing understanding of ourselves as “ historically emerging being[s] ”(Gergen and Gergen (1983: 254). The self-narrative provides a means to place our life events in some kind of temporal order leading to an end point: the destination of “directionality” (Gergen and Gergen 1983: 257). Narrative allows us to begin to make sense of the past and find direction for the future and through the process of telling to another, we can create “dramatic engagement”, a performance that can be highly expressive of emotion and concerns (Gergen and Gergen 1983: 261). Robinson (1990) uses the framework Gergen and Gergen (1983) developed to analyse 50 research narratives from people with MS. This involves drawing on the two key forces identified in the framework: coherence (a person’s core sense of purpose in life) and direction (movement towards or away from fulfilling this purpose). In the framework these forces are seen as enmeshed within “three narrative forms, stability, progression, and regression” (Gergen and Gergen 1983: 259). Stability refers to accounts that demonstrate constancy of purpose throughout, while progression demonstrates movement towards life’s purpose, and regression, movement away from purpose. Movement or slide between these forces upwards and downwards creates the dramatic tension that shifts the narrative and reveals “the tragedy, comedy-melodrama, the romantic saga” (Gergen and Gergen 1983: 258).

Robinson (1990) discovers that out of his sample, despite living with a chronic condition, 52% of the narratives manifested progressive features affirmative of purpose, with 20% manifesting stable features, and only 10% regressive features (18% were not possible to categorise). On further interrogation he identified nuanced features within these forms, for instance in those within the progressive form there were heroic narratives characterised by a combination of being self-effacing with affirmation of life, and in those within the regressive form there were sad or even tragic narratives that at the extreme were characterised as accounts of “a death in life” (Robinson 1990:1183). Overall, however, the narratives reflected an affirmation of purpose: “the importance of the personal quest both for meaning, but more particularly for mastery over the unpredictable physical course of the disease” (Robinson 1990:34).

Social researchers like Robinson (1990) collect and analyse illness narratives with the aim of empowering ill people and facilitating a process whereby, “testimony is given equal place alongside professional expertise” (Frank 1995:145) a necessary redress when the professional focus acts to eclipse acknowledgement of the meaning-making in the everyday, including understanding of existential realities of this lived experience (Mishler 1984).

Frank (1995: 97; 110; 115) recognises in the stories from people with a range of conditions themes or storylines that fall into three types: the “restitution plot”, a “chaos narrative”, or the “personal quest” story. The “restitution plot” encompasses accounts that focus on beating the illness and returning to health, while the “chaos narrative” refer to accounts where control over the illness, and directionality more generally, are lost. In contrast, “personal quest” narratives refer to accounts where acceptance is reached and control restored.

Bury (2001) also identifies three narratives types. His category of “contingent narrative” (2001: 274) focuses on the origins of the condition and subsequent consequences for daily living, while “moral narrative” types focus on the disease trajectory and its multifaceted implications and how the disruption “can be turned in self discovery and renewal” (Bury 2001: 276). Finally, “core narrative” types that “may convey ‘stable’, ‘progressive’ or regressive’ qualities” but are characterised by accounts that engage in meaning-making at both a personal and a societal level (Bury 2001: 280).

Narratives for research involve the story teller and the listener/audience (the researcher) going into “the space of the story *for* the other” (Frank 1995: 18). This space enables the story teller to make-sense of their life in the presence of another who will interpret/translate it to share as a statement to a wider audience (Haraway 1991). As Kierans (2005:350) notes, the telling of the story bestows: “the ability to create meaning, to revise past experiences, to emplot significance, establish coherence, and, most centrally, to orient....towards the future.”

In this sense the story told needs to be understood as whole rather than as fragmented parts (Riessman 2008), and is inextricably connected to the relationship between teller and listener/audience (Etherington 2007). This makes the story contingent, ambiguous and “partial”: a privileged glimpse into the meaning and experience distilled in that specific situation (Haraway 1991:350; Robinson 1990; Bury 2001).

*Ricoeur’s theory of interpretation*

To understand the meaning of these stories from people with MS this study will turn to Paul Ricoeur’s theory of interpretation, and his exploration of temporality in narrative in the essay *Narrative Time* (1980), and the study, *Time and Narrative* (Ricoeur 1984), volume one of a three-volume work. These works, and others of his also drawn on, explore how narrative relates to time and brings forth existential features. Ricoeur principally relates his theory to written historical or folklore narratives, but also accepts that meaning-making can be mediated through written stories of lived experience (Ricoeur 1984).

The narrative form provides the connective elements in the telling of events and incidents and often appears to us as linear and successive because it lays out the plot or ‘emplotment’ and serves the function of holding the events together. Where possible, we tell and read fictional and factual narrative accounts because they can convey entertainment or information, usually missing or failing to articulate to ourselves (unless we are struck by an immediate existential recognition) what Ricoeur’s theory of interpretation focuses on: the glimpses of universal aspects of the everyday; “the spiral movement that, through anecdotes and episodes, brings us back to the almost motionless constellations of potentialities that the narrative retrieves” (Ricoeur 1980: 188). In the recounting of events of lived experience, the autobiographical triptych becomes harmonised through the process of “making present” temporal features of the narrative to the audience with the end point of the narrative providing the wholeness from which overall meaning can emerge (Ricoeur 1980: 177). Ricoeur acknowledges that the meaning elicited is an interpretation rather than representation of truth and presents in a compound because “self-understanding is an interpretation; interpretation of the self, in turn, finds in the narrative, among other signs and symbols, a privileged form of meditation; the latter borrows from history as well as from fiction, making a life story a fictional story or, if one prefers, a historical fiction, interweaving the historiographic style of biographies with the novelistic style of imaginary autobiographies” (Ricoeur 1992:114 cited in Friedman 2010: 163-4).

Ricoeur relates this spiral movement required for interpretation to ‘Mimesis’ which divides into three mimetic stages, beginning with Mimesis1: prefiguration. This can be understood as an initial naive interpretation that takes at face value an “existing understanding of the world” (Simms 2003: 86). This is followed by Mimesis2: configuration. This provides a structural analysis and facilitates the pivotal mediating role between the first and last stages of mimesis by allowing an opening up of interpretative possibilities. It allows consideration of “such things that might be”, rather than of how “things that have been” (Ricoeur 1984: 40), thereby creating space for the imaginative leap required for the “poetic act” found within Memesis3: refiguration (Ricoeur 1984: 64). This is the final phase of the hermeneutic circle providing the critical interpretation of the whole with reference to metaphor and poetry that: “produces new ways of knowing”, and [which] allows meaning to emerge (Laranjeira 2013: 472).

This hermeneutic circle promotes distance through what Ricoeur refers to as distanciation (Ricoeur 1973): “the effect of being made *distant* from the producer of the text and the cultural conditions under which he or she wrote” (Simms 2003: 39). Through the process of transforming the orally delivered story to text it becomes liberated from the original delivery and takes on a meaning over-and-above the context in which it was told, with its inevitable distractions in the mundane. This contributes to the narrative becoming more objective and allows “communication within and by means of distance” (Ricoeur 1973:130). Distanciation creates the space to mediate between the narrative and self-understanding, between narrative and understanding of another, and narrative and understanding for the wider world (Laranjeira 2013). In this way the narrative provides the opportunity for the recollection of events and thoughts that have become reconfigured or subject to “refiguration”, in ways that reveal existential realities of what it is to be-in-the-world, beyond the literal meaning given, or necessarily the original meaning intended (Ricoeur 1984: 64).

*Method*

Ricoeur’s theory of interpretation has been adapted as a method in an attempt to understand the temporal and existential realities woven within the narratives of people living with MS. It should be acknowledged that Ricoeur did not develop his theory as a method, so the spiral process described below for textual analysis is an adaptation of his theory. It draws on prefiguration, with its implied naive interpretation; configuration, with its implied structural analysis; and refiguration, with its implied critical interpretation. These levels of interpretation have been used by other social researchers to assist in the process of adapting his theory into a method to facilitate moving “forwards and backwards between parts and the whole in a dialectical way and between explanation and comprehension in a circular way” to elicit meaning as a whole and the key meaningful elements within the whole (Dreyer and Pedersen 2009: 65; also see Angel et al 2012; Missel and Birkelund 2011; Tan et al 2009; Geanello 2000).

The hermeneutic circle and ensuing distanciation is appropriate as a method when the intention is to distance the process away from the research participant’s mundane everyday issues, towards an understanding of meaning-making over time as revealed woven within the recall of the every day. This distance however, also provides the major limitation of this method, as distanciation, by removing the story from the situated cultural and socioeconomic circumstances, limits understanding of the specific concerns raised within the narrative.

For the study ten participants with MS were recruited from across the North of England through a regional therapy centre that offers support to a range of health conditions (February 2015). The features of the ten stories specifically relating to events and issues raised are not focused on in this analysis and paper but have not been ignored because they highlight significant issues relating to the care and management of people with MS, and so have been analysed thematically for another paper, so using the narrative data to find “a middle way” between the meaning woven within text and the specific concerns told (Ezzy 1998: 169). Two of the analysed narratives are presented and were chosen because they offer very different ways of making sense of life and finding meaning under the compromised circumstances of having a chronic condition.

Ethical approval was given by the University Non-Invasive Ethics Sub-Committee (July 2014), and informed consent was sought in a continuous process from initial verbal sharing of information through to reconfirming consent after written consent was given, and again after the narrative interview had taken place. Other than the opening question, which asked participants to tell their story related to the onset of, and adjustment to MS, the direction of the interaction was participant-led, allowing the space for the participant to have control over what they shared in their story. Pseudonyms have been used with other identifying information removed.

*The narratives*

For each narrative the three stages of interpretation: naive, structural, and critical are presented. Each begins with a brief summary of the naive interpretation, followed by four or five numbered structural interpretations of the précised text taken from each narrative. These structural interpretations provide the basis for the imaginative leap required for the “poetic act” and final critical interpretation (Ricoeur 1984: 64). This critical interpretation will be accompanied by a short phrase from poetry believed to capture something of the existential reality interwoven within each narrative (Ricoeur 1980: 177).

*Edwin’s story- naive interpretation*

The initial interpretation of Edwin’s story is of two halves. The first half is about his professional life before the onset of MS, when he was running his own solicitor’s firm and living a fast-paced successful and stressful life. The second half is about how the onset of MS took these “successes away”, but also reduced the demands and pressures Edwin had faced.

*Structural interpretation 1- Past time lived at a different pace*

From the outset of Edwin’s narrative he makes a clear distinction between his “past life” and his present one. This past life is before his diagnosis when the pace of life was lived at high speed and events overtook him as he hurtled out of control until life as he had known it was brought to an abrupt halt by a car collision, swiftly followed by a diagnosis of MS.

*1995, going through a divorce; running my own business; I had a car accident; I was a solicitor – past life as I call it – I was going through a person injuries claim – it was my fault – doing the personal injury claim myself, went to see my own GP and he asked me to do the usual drink drive test, where you put one foot in front of the other, I couldn’t do it – no chance. So I was referred to the City Hospital, with big letter on the ward saying MS, I’d never even heard of it. MRI scan, diagnosed, put on steroids I think for 3 days with a big list of tablets to swallow that I took for 12 months.*

*Structural interpretation 2 - Powerlessness: the endless round of drug treatments*

Edwin recalls the endless round of Disease Modifying Drugs (DMDs) he is offered in a treatment regime that seems to revolve around trying one and if that does not work, moving onto another, together with rules and regulations concerning eligibility. That is, until the diagnosis of secondary progression, and then he is left to absorb the pain of this with the statement “we’ll see you in 12 months time”, and nothing more. It is as though the medics have washed their hands of him in his moment of suffering.

*“I was very naive back in 1995, there was an injection, DMD, by the name of Beta Interferon – smashing – that lasted possibly about 3 or 4 years. We then moved to an injection called Avonex intramuscular. After a while that ran its course and then back to the hospital again. “Now we’ve got a new one for you: try Copaxone”. So we had a go at that. Then had what we thought was a relapse, and a new MRI scan. This is now thirteen years later, the consultant says, “Well there’s additional lesions on the brain so clearly the Copaxone is not working – Copaxone’s not working and you’ve become secondary progressive. So we’re going to withdraw it.” – Okay: fine. So what’s the alternative? By this time we’re getting very, very cynical. One consultant was considering a more aggressive treatment, and his response was “Looking at the rules and regulations you’re not entitled to it because you’re too old, you’ve got to be in your 20s and had two serious relapses in a six month period”. So that was it – what’s next? “We’ll see you in 12 months,” and that was it!”*

*Structural interpretation 3 - Let sleeping dogs lie: trauma/stress*

It is the accident and the stresses in Edwin’s life that he sees as acting as a trigger for waking the dormant MS in his body, and marking his past life off from the life that is to follow. He is resigned to the realisation that the cause of MS is unknown.

*I see the accident as a trigger – no more than that – it triggered something that was obviously underlying but why I just don’t know. But it isn’t like the experts know what it is. Talking to a lot of people, I think if there is a common denominator it seems to be stress, but as I say again, it doesn’t solve the problem with how you get that underlying susceptibility to MS. Definitely not the cause, no one has a clue what the cause is.*

*Structural interpretation 4 - Acceptance and carrying-on*

Edwin’s account acknowledges he initially struggled to come to terms with having MS, before accepting that this was something he had to live with rather than fight.

*You have to get on with it, and you do. You could curl up and feel very sorry for yourself, which is what I did for the first year after diagnosis, running a business and drinking far too much alcohol – feeling very sorry and thinking “why me?” and then waking up one morning and thinking “Why not me, get on with it!”*

*Structural interpretation 5 - Making-present: in solidarity*

Edwin associates his past life with stress (the trigger for “waking up” his MS) but, in the present, he has taken on a new outlook that banishes stress. He looks back to early unidentified symptoms of MS and his relationship with his deceased father. Edwin taught his father squash while his own physical dexterity was deteriorating, leading to his father eventually beating him. The recollection is warm and affectionate: father and son sharing a joke in solidarity.

*Now I don’t do stress, stress has gone. I got rid of it out of my life altogether. I don’t do it – if there’s a problem we solve it but I don’t do stress. It’s a new outlook on life, really. I look back and think, why did I used to get so stressed? – Probably the responsibility of running a business etc, but that’s, as I say, my past life now. Looking back in hindsight is a wonderful thing. A very good standard of squash, - my father, God rest his soul now, I encouraged him to take up squash. I thought it was a great idea. There was a lot of competition between the two of us. I used to absolutely annihilate him but as the years went by I thought hang on a minute, he’s close to winning that game, and a couple of months down the line, you know what: my Dad’s just beat me! It just became the case and quietly the progression of the illness – that’s what I think; he wasn’t that good anyway, I’m sure he’s listening up there. I’m sure he’s laughing.*

*Emma’s story - naive interpretation*

The initial interpretation of Emma’s story is one that tells only half her story and that is at times confused and sad, and dominated by an unhappy childhood and the early death of her mother and difficult relationship with her father. After diagnosis in early adulthood the story ends.

*Structural interpretation 1 - Time present: the embodied self*

Emma begins by settling down to tell her story.

*“I’ll probably jump about. I’ve now got oedema which is common with people who sit around doing nothing. This is why it’s good for me to try and get up and make a drink and sit down and get up.”*

*Structural interpretation 2 - Past time: being abandoned*

Emma’s narrative focuses on a very unhappy childhood. She had a very difficult relationship with her father following the death of her mother with MS. Emma sees her mother’s death as a release from suffering. Soon after, her father started a new relationship and Emma found herself doing all the house work, eventually being thrown out of the family home by her father.

*“Well my Mum had MS. Mum died when I was 12, on Valentine Day – and a year later I came home from school and my Dad was sat on the settee with this woman, so I walked out. I didn’t have a good relationship with my father and his attitude with me – well I know before Mum died it wasn’t easy for him because Mum was in and out of hospitals, one time she was in a nursing home for a year and when she came home she had a bad relapse, and we were sat in front of the television, and Dad came through with slack for the fire, and said get a Doctor...later that night she died. How can I say this – it was sad and but we didn’t cry because she’s wasn’t suffering anymore. She wasn’t quite 48. It can’t have been easy for Dad as his English wasn’t good and he had to work all the time. He never had time off to look after Mum ....I hated doing the cleaning and – I hated changing the beds but I did it because I had to. He used to go to the pub every Friday night but he needed to. He needed people to talk to and he couldn’t always talk to children. And then he threw me out and I had to be taken care of by social services.”*

*Structural interpretation 3 - Alone*

This difficult childhood left Emma alone to cope with a job and symptoms that she did not initially understand. When she did learn she had MS she did not at the outset associate it with what her mother had and her concern was for her father rather than herself.

*“I had these symptoms and I was staggering so I kept going back to the GP, and they referred me to a doctor at the hospital but they couldn’t find anything wrong with me, so off I went. Then it got worse, only this time I couldn’t walk and someone I knew was kind enough to take me in and leave me at the hospital. I saw the consultant neurologist and he said, “Right I want you in.” I think I might have been in there for two weeks. They did all the tests and the first thing I had was an injection in my bottom and I improved and then physio got me walking again, and then I was discharged. None of them said I’d got MS and I was wondering what on earth was wrong. Then I had a number of relapses and in the end I had to give up the job because it wasn’t helping. I kept going back to the GP and eventually, when I couldn’t walk so they gave me a lumbar puncture in the hospital and then told me I had MS. My immediate thought was what am I going to tell my Dad, how can I hurt my Dad anymore than he’s been hurt already? And I never told him. It’s not hereditary but it’s familial – so my MS wasn’t like my Mum’s. I didn’t associate the two but on reflection it must be.*

*Structural interpretation 4 – Suffering in silence*

Emma receives her diagnosis in her twenties at a time she is trying to establish her life and fears being alone. Her condition leads to the loss of her car, job and friends and, she decides, also her fertility, when she takes the decision to have a hysterectomy. The operation in itself causes her long-term pain and health problems. Emma’s story is cut short by the MS because for her, thereafter it is all in the past.

*“I know I was frightened of being on my own and of course I’d given up the car and wasn’t able to go back to work and finding out I had MS meant there was no way I was having a child. There was no way I was going to bring a child into the world with what I’ve got. No way, how could I? And then what if that child had got what I’ve got? I had a hysterectomy when I was 30. After having a hysterectomy I had to go the hospital many times to be catheterised. Now I get a box of catheterises – now I can do it myself 3 or 4 times a day. I’d only recently moved up here and got a job, and I wanted to work and have friends but it ended for me with the MS.”*

*Critical interpretations – making present: the poetic act*

Both narratives expose aspects of the stories that are particular to each and their specific life circumstances, but, also, more universally recognisable traits about how to live and find meaning especially when agency is compromised. Edwin’s narrative follows the structure of his past life, and re-negotiated present and future and how he has found a way to live well in a very different life to the one he anticipated as a young man. He had placed hope in medicine before feeling abandoned by medics when his MS became progressive and he failed to ‘fit’ the criteria for drug treatments. Reflecting back on the years he spent on DMDs he is cynical about whether medicine has been of any benefit to him. Instead he sees his future wellbeing lying with his ability to eliminate stress in his life, the trigger he identified for exacerbating his symptoms. An existential reality made present interwoven in the whole is that Edwin has moved into “another intensity”, a deeper level of consciousness where he is in harmony with the past and hopeful for the future (Eliot 1982:188).

In contrast, the structure of Emma’s narrative is all in the past, indicating the present occupies a space without hope for the future. In this sense her story is not a triptych at all because it contains no “new-future” life envisaged. The kernel of action and concern is presented as before the age of thirty, and all thereafter is living day-to-day without anticipation. The absence of concern in the present, in contrast to her past, implies a kind of calm and so the present/future is not necessarily empty for Emma. But as a young woman she had feared being alone, and unfortunately, it seems that this fear was realised when the MS took away, in her eyes, any possibilities of avoiding this. An existential quality that is made present and suffused through the whole is “the future futureless”, where the past is full of suffering and the future offers calm that comes from having few expectations (Eliot 1982:185).

*Discussion*

Social researchers have provided narrative categories to assist in analysis of illness stories and lend credibility to the methodological rigour. For instance, Edwin‘s story could be seen as taking a progressive form, perhaps even being a heroic narrative, and/or moral narrative, and/or “quest narrative” (Gergen and Gergen 1893; Robinson 1990; Bury 2001; Frank 1996: 115). This is because Edwin presents himself as having overcome the dark days after diagnosis and, through acceptance, discovered a new outlook on life.

Emma’s story might be seen as taking a regressive form and even being a tragic narrative, and/or chaos narrative, with her schematic structure and account of diagnosis closing down any possibility of achieving her life’s purpose (Robinson 1990; Frank 1995). In this study however, there is an acceptance that the narratives are to a degree “imaginary autobiographies” (Ricoeur 1992: 114) with the focus of interpretation located around the symbolic and poetic message revealed while recognising that “the supremacy of poetic function over referential function does not obliterate the reference but makes it ambiguous” (Ricoeur 1978: 264). Having a degenerative chronic condition necessitates a re-interpretation of self and being-in-the-world which directs contemplation to the existential, perhaps in ways that others might be too busy or fearful to contemplate, and in ways that are largely unacknowledged by interdisciplinary professionals committed to supporting people with chronic conditions.

Quite apart from the importance of these narratives for Edwin and Emma, two people who, by consenting to participate in this study, implied that they believed they had something to communicate about living with MS to a wider audience, and the importance of these narratives for each of us who are continually re-interpreting our own life stories, self-identities, and places in the world, such stories have much to tell professionals working with people with chronic conditions. Not necessarily with regard to the specific content but more to the meaning negotiated and the impact of the condition on hope and values. Professionals need to be open to the opportunities to come alongside the embodied person and join them in the same inertial frame by developing an “ontological intelligence (a perspicacious view of the nature of ‘being’)” that challenges technical and procedurally driven practice that will, for example, leave a person with a sense of abandonment at the point of being told their condition had progressed, or when a person is so alone that they live without any hope or sense of solidarity (Houston 2010:843). It is about finding the space for dialogue where “competing and potentially conflicting values and outcomes” can be revealed and validated (Parton 2002:9).

Finding the space to allow service-users to tell their stories can have an important therapeutic value. As Ricoeur’s theory of interpretation implies “we understand our own lives – our own selves and our own places in the world – by interpreting our lives as if they were narratives, or more precisely, through the world of interpreting our lives we turn them into narratives, and life understood as narrative constitutes self-understanding” Simms (2003:80). The exposure and release gained through the telling of the illness narrative is exemplified by Julia when reflecting on living with kidney failure: “you have to get it outside yourself and it took me ages to realize that that is what the loneliness is; it is the lack of narrative” (Kierans 2005: 343). For Ricoeur, what Julia describes is the process of “making present” and it is from this that “the instance of suffering and acting” is exposed (Ricoeur 1980: 177) and where, for the person isolated by a degenerative chronic condition, “the common bond of suffering that joins bodies in their vulnerability” becomes revealed (Frank 1995: xi).

*Conclusion*

This paper has drawn on Ricoeur’s theory of interpretation to understand the place of narrative in sense-making and how narrative can take account of the temporal aspects of experience and reveal existential realities woven within the accounts given. Ricoeur’s theory has then been adapted as a method to facilitate the spiral process required for a critical interpretation beginning with an initial naive reading of the narrative, before engaging in a structured analysis, leading to the final critical interpretation and symbolic and poetic reference.

It has been argued that there is value in inter-disciplinary professionals making the space for people with MS and other chronic conditions to tell their stories because of the twofold benefits of assisting service-users to make-sense of life under compromised circumstances, and reveal to professionals, a person’s sense-making so they can glimpse the values, hopes and fears and other existential realities they hold. This can inform assessment of appropriate support to assist a person to live life well.

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