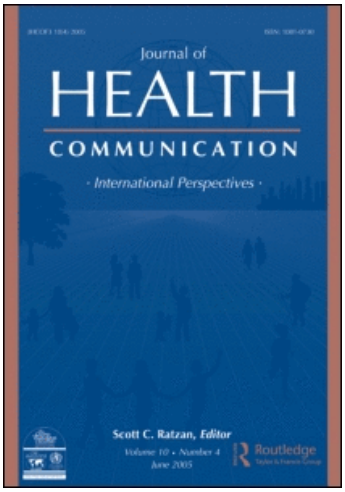

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Narrative Intervention in Behavior and Public Health

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Public health interventions using narratives, or stories, as a means for encouraging behavior change are common, especially in the developing world. Entertainment-education (EE) is perhaps the most widely researched form of such "narrative intervention," but many other kinds of interventions, or parts of interventions, rely on stories to convey information about behavior risk and to model risk avoidance. Although narrative interventions are often grounded in social-cognitive theory and in commonsense assumptions about the power of storytelling, they are generally undertaken without much regard for the philosophical and cognitive bases for narrative about which much has been written. Many aspects of narrative intervention in behavior and public health could be better understood in light this literature. These include the 1) challenges inherent in creating and building on a discourse around behavior change in non-Western contexts; 2) current emphasis in public health on production rather than reception and the fundamental problem of interpretation; 3) differences between messaging versus providing an alternative worldview, and finally; 4) issues surrounding the appropriate approach to the evaluation of a narrative intervention.

> *"Everyone lives in a story," Tridib says, "My grandmother, my father, his father, Lenin, Einstein [. . .] they all lived in stories, because stories are all there are to live in, it was just a question of which one you chose."*
> Amitav Ghosh, *The Shadow Lines* (1990, p. 182)

Motivating people to alter their often unconscious and culturally endorsed behaviors in a way that reduces the risk of accident or illness is a natural public health objective. Yet behavior change is complex both as a phenomenon and as a topic; several departments within the average university can claim, with some justification, that human behavior is their specialty. But almost all specialists in human behavior, regardless of academic background, agree that the ability of individuals to contextualize behavior is fundamental to behavior change. The adoption of new behavior does not unfold in isolation but as part of a dense web of social, environmental, and intrapersonal interactions. This web is not without structure, but is experienced by individuals using an array of indexing principles that connect themes, archetypes, chronologies, commonplaces, and motives. In other words, one could argue that behavior change is essentially accomplished by weaving together past and present perceptions into coherent stories, or narratives.

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This is not an original observation. As Michael Slater (2002) notes, "the use of story-telling to influence behavior is at least as old as Aesop and is deeply ingrained in Western as well as non-Western cultures" (p. 158). Elsewhere in public health, Ford and Koetsawang (1999) note, "The special power of narrative, linking emotion, empathy and appeal, arises perhaps from something innate in human consciousness, as has been documented since Aristotle" (p. 223). Narratives not only help us impose meaning on the world around us, but also create frameworks for "possible worlds"—to use Jerome Bruner's (1986) elegant phrase—in which our lives might be otherwise. But while several fields have caught the narrative "bug" for several decades now, the field of public health communication may not be as familiar with the interconnections among stories, thought, and action. Accordingly, health communication practitioners have been slow to systematically examine the implications of narrative for public health interventions at home and abroad. Even those health communication strategies that rely overtly on storytelling, such as "entertainment-education" (EE), sidestep narrative as a conceptual framework. While the literatures of behavior change communication and EE (in the form of soap operas, novels, theatre, ballads, serialized comic strips/fotonovelas, etc.) frequently allude to social-cognitive theory and role modeling as proposed by Albert Bandura (1986), the fact that role models are *characters* whose behavior is only understood within the context of a story goes largely unremarked and unexplored.

Paradoxically, then, while what I will term "narrative interventions" such as EE are proliferating (Nariman, 1993; Sherry, 1997; Singhal, Cody, Rogers, & Sabido, 2003; Singhal & Rogers, 1999; Tufte, 2001), sustained examination of how narrativity shapes understanding and motivates health-related behavior change remains rare. The objective of this article, then, is to prompt what Tversky and Kahnneman (1981) might call a "(re)framing effect": to demonstrate that by casting interventions such as EE as a variety of narrative intervention, new issues come to the fore.

The Narrativity of Knowledge and Memory

Public health's investment in narrative has roots, however tacit, in one or both of two beliefs: that stories reflect and contribute to what we take to be the "real world" and that stories are a means of encapsulating knowledge in memory. In slightly more disciplinary terms, one might say that narrative has an *epistemological* dimension that philosophers are primarily charged with investigating and a *cognitive* dimension that psychologists examine (Petraglia, 1998).

In a succinct expression of the epistemological importance of narrative, literary theorist and rhetorician Kenneth Burke (1941) describes the human condition using the metaphor of a "parlor" that all of us enter upon birth. We arrive late to find others in the parlor already engaged in conversation about every topic imaginable. We do not grasp the full meaning of any of the conversations because we are walking in without benefit of knowing their starting points, original purpose, or all of what has been said preceding our arrival (we can access synopses in the form of historical accounts and stories that are passed along to us from others, but these are inevitably partial and fragmented). After a period of listening in and figuring out the conversation's assumptions, commonplaces, and conventions, we start to get the hang of it, contribute to the conversation for awhile, and then, upon our death, depart the parlor. But the conversation does not end, of course; the parlor goes on, welcoming newcomers who, like us, pick up and advance the threads of earlier conversations

ad infinitum. Through Burke's metaphor we can see the centrality of narrative; essentially, the "conversations" we confront in the parlor are on-going stories that have already set out the parameters of archetypical characters, plots, and settings and we participate in the storytelling process by making sense of our own experience in light of prevailing narratives.

This "constructivist" stance (some variation of which is accepted in most humanities and social sciences and increasingly in the physical sciences as well) suggests that an individual's knowledge of the world, including knowledge about his or her health and how it may be put at risk or promoted, draws from prior experiences, socially sanctioned norms, and private interpretations that are woven into stories about who we are and how we got here. From this broad epistemological perspective, then, many would argue that the role of narrative can hardly be overemphasized in any arena of human behavior and particularly so in the area of public health.

Although public health's interest in narrative can be seen through a philosophical lens, this interest also is deeply rooted in cognitive science and the very building blocks of memory: schemas. As explained by Fiske and Linville (1980), studies of human memory and thinking suggest that memory is packaged into networks of nodes (schemas) that create associations among knowledge, experience, and attitudes. Schemas are a means of organizing "prior knowledge, abstracted from experience with specific instances that guides the processing of new information and the retrieval of stored information" (Schank & Abelson, 1977, p. 96). For instance, some elements in my schema for "restaurant" include:

- In expensive restaurants, someone seats you; in fast food restaurants, you seat yourself.
- One orders food listed on something called a "menu."
- My sister got sick at a Thai restaurant once.
- I hated the film "My Dinner with Andre."
- Carla is trying to save money by eating at home more often.

Naturally, not all of this information is brought to consciousness every time someone mentions the word *restaurant*, but my brain is nevertheless primed to access this information if further inputs (perhaps someone asking me to go to lunch) suggest that additional parts of my schema need to be instantiated.

Although schemas may be thought of as small ideational units, when packaged together in larger chunks, they form scripts (Schank & Abelson, 1977) that, over time, build up expectations of causes and effects. Collections of scripts, in turn, form the web of interconnected stories that we call the mind. Memory, then, takes on certain features we associate with narrative. First, narratives are peopled with archetypes—"typical" characters such as jealous husbands, spoiled children, wise elders, absent-minded professors, and so on. As with schemas, narratives generally reinforce simple themes (e.g., Too much rain means crops won't ripen. People who abuse drugs will not keep a job, etc.). Narratives are especially useful in helping us determine what a particular event is "about" and to filter out information that may be irrelevant. Schemas prime memories that enable us to identify a situation's putative causes and effects by matching current experience with past experience. In this way, narratives enable us to anticipate outcomes (e.g., "Here in France, I'll have to ask for the check because the server won't automatically bring it.") and make inferences (e.g., "Because it's not on the menu, I probably shouldn't ask for it.").

Because narratives are more complex than simple schemas they can embed foundational storylines in memory (e.g., Inexperienced people make mistakes, but they learn from them, and don't make them again. Boy meets girl, boy and girl's parents try to keep them apart, but love prevails, etc.). Keith Oatley (2002) has suggested how narratives encourage us to link emotions to actions and Derek Edwards and Jonathan Potter (1992) argue that "narrative offers a useful discursive opportunity for the fusing of memory and attribution, or of event description and causal explanation" (p. 161). From a cognitive perspective, narratives work closely with metaphors to adjust particulars from one situation to make them fit another. Metaphors, like narratives, are vehicles for making new information recognizable—for instance, when confronted with novelty we understand automobiles as "horseless carriages" (cf. Lakoff & Johnson, 1980). In an important sense, narratives are extended metaphors—richer and infinitely more complex, perhaps, but similar in that they make novelty comfortable by linking the unknown to the known and permitting comparison.

Thus, from both humanistic and social scientific perspectives, narratives are the shape that all experience ultimately takes. Psychology, like philosophy, recognizes that stories are critical to situation recognition, appraisal, decision making, and subsequent behavior. Narratives package memory in usable form and make pattern recognition possible as well as impose a kind of logic and moral coherence on our experience. Seeing our lives unfold in a comprehensible way keeps chaos at bay and, literally, keeps us sane.

From Narrative to Narrative Intervention

Humans might be described as *homo narrans*; the ability, indeed the need, to think using narratives is a hallmark of our mental processing (Fisher, 1987). Polkinghorne (1988) is not overstating the case when he notes that "narrative is the primary scheme by which human beings take form"(p. 123). But even if we accept that storytelling is a dimension of all perception and thought, those of us in public health are still left with questions of whether, and how, we can consciously manipulate narratives in ways that foster healthier behavior.

Although my opening premise was that the public health community at large has not spent adequate time theorizing narrative *intervention*, narrative *therapy* lies at the very heart of at least two areas of non public intervention: mental health and clinical practice (e.g., Harter, Jaap, & Beck, 2005; Lieblich, McAdams, & Josselson, 2004; Mattingly, 1998; Sharf, 1990). At one level, of course, the objectives of both narrative intervention and narrative therapy are similar; both try to help people emplot their memories, experiences, and expectations in ways that elicit information, permit change, or make experience comprehensible. In practice, however, narrative intervention and narrative therapy are different in important respects. First, the methods of the latter differ greatly from those of those of the former. In narrative therapy, the therapist elicits raw experience and then helps the client narratize that experience to make it easier to articulate, understand, reconcile, and revise (Muntigl, 2004). Conversely, in most narrative-based public health interventions, the health professional generally provides narratives and asks the audience to understand their own experience in light of them. Public health interventions using narrative, unlike narrative therapy, are almost always prevention-oriented rather than curative. Logistically, whereas narrative therapy is intensely focused on individuals who can "afford"

(in every sense) to work with narratives in a very close and focused manner, narrative intervention is usually aimed at a collective population of potential beneficiaries using mass media. So while there is much public health professionals can learn about the nature of narrative intervention from the field of mental health and clinical practice, it may be more useful to consider how narrative intervention is distinctive and distinctively problematic.

To this end, the remainder of this article reviews the following interrelated topics: (1) the challenges inherent in creating and building upon a behavior change discourse in non-Western contexts, (2) the current emphasis in public health on story production rather than reception and the fundamental problem of interpretation, (3) the difference between messaging versus providing an alternative worldview, and, finally, (4) issues surrounding the assessment of narrative intervention.

Cross-cultural Differences Related to Narrative

Frederick Bartlett's (1932) early, elegant experiments in memory based on story recall throw considerable light on cultural difference and narrative. Although his research was designed to demonstrate the decay of long-term memory over time, his studies illustrate two issues relevant to the topic of narrative intervention: first, the importance of "folk" psychologies and, second, the impact of primary orality on narrative understanding.

Generally, behavior change interventions depend on people's *conscious* efforts to understand the behavior change ideas being communicated in narratives. This assumes that everyone everywhere shares a basic understanding of behavioral cause and effect, or what might be called a "folk psychology of behavior change." For instance, one might say, "I fall off my diet when my Mom comes to visit because she makes all my favorites," "I find I need a cigarette when I'm bored or need to do something with my hands," or "I continue to try to exercise more (even though I'm unsuccessful) because I want to set a good example for my kids." Such statements reflect a kind of Western folk psychology that bear a striking resemblance to the transtheoretical model of behavior change (Prochaska, Redding, Harlow, Rossi, & Velicer, 1994) and notions of self-efficacy, role-modeling, and social learning that figure prominently in the public health literature on behavior change.

Because the West has settled on so many of these constructs for such a long time, it is only natural that contemporary discourse about behavior is, for the most part, Western discourse (Danzinger, 1997; Gergen, Gulerce, Lock, & Grishwar, 1996; Gergen, 2001). Call-in radio shows, "agony aunt" advice columns, and talk show hosts such as Oprah Winfrey and others reinforce key behavior change ideas to the extent that they are almost commonsensical to the average media consumer. Constructs such as "enabling" and codependence and the importance of support networks, self-confidence, and so on, feature prominently in many people's vocabularies. But while we can easily imagine our friends (and maybe ourselves) uttering commonsense statements similar to those in the paragraph above, is it reasonable to assume that Nigerians or Thais would? The point is that effective narrative interventions must be designed with local folk psychologies of behavior change in mind. If our goal is to change behavior, we have to know whether we are either aligning our stories with existing social narratives or purposely

seeking to inject new and perhaps disruptive narratives of change into a given population.

The second issue, one related to that of differences among folk psychologies, is the role of narrative in cultures that can be described as primarily oral (Luria, 1976; Ong, 1982). A primarily oral culture is one in which skills of objectifying thought through writing does not happen as naturally or pervasively as it does in literate cultures. Some theorists have argued that people from primarily oral cultures are less able to systematically manipulate ideas than are people who use writing as a means of externalizing thought. The claim is understandably controversial if not carefully qualified, but the essence of a good point is here nonetheless: getting people to *externalize* and alter harmful narratives when they only have experience manipulating them in their heads poses unique challenges. It may be that narrative interventions, usually designed by members of highly literate cultures or the literate elite within primarily oral cultures, will find it difficult to connect with less literate audiences accustomed to different narrative conventions and cognitive heuristics.

In short, the existence of a public discourse around behavior change that makes an intervention comprehensible is prerequisite to narrative intervention using mass media. Complicating this further, such a discourse may not exist in corners of the world that are relatively dependent on oral modes of storytelling that do not make as much use of abstraction as literate modes necessarily must.

Resurrecting Reception

For at least a century, education and communication have been inextricably linked to the idea of reception: the ways in which audiences make sense of the information that is being communicated to them. An interest in narrative only makes a concern for reception even more fundamental. But while reception continues to figure heavily in communication theory and remains a staple of research in EE (e.g., Chitnis, Thombre, Rogers, Singhal, & Sengupta, 2006; Papa et al., 2000), *as a public health practice*, EE seems preoccupied with the production of narratives to the detriment of attention to how those narratives are understood. Published accounts of intervention design and evaluation demonstrate few concerns about individuals' receptive processes or what individuals took away from the narratives presented to them. Similarly, conferences on EE and public health communication also tend to focus almost exclusively on the production rather than reception of narratives.

In other words, narrative-based interventions often invest enormous energy in scripting the "right" narratives—creating stories that are engaging, esthetically pleasing, culturally appropriate, and behaviorally sound. And, accordingly, when EE interventions come under criticism, often it is for their perceived shortcomings in these areas. The assumption is that the right story will have a widely salutary effect. The opposite of "garbage in, garbage out," production-focused interventions are premised on the belief that good public narratives beget healthy private narratives. Of course, production is absolutely vital for narrative intervention, and to privilege reception over production is akin to privileging the diastole over the systole when describing heart functioning, but the point remains that public health practice is often production-driven.

There are at least two contributors to what I perceive to be the neglect of reception in public health practice that warrant brief mention. Most interesting to me, perhaps, is the way in which public health, like many other disciplines, has experienced a

move away from the autonomous individual toward a broader appreciation of social action in shaping health behavior (Tufte, 2005). Because the cognition involved with reception often is associated with a narrow focus on individual processing, reception has been pushed to the margins in many social sciences (Baars, 1986; Danzinger, 1997). When cognition is raised, it is in terms of the aggregate cognition of a class of persons rather than the way in which an individual has brought his or her unique history and experience to bear on the narrative. The second important factor that I believe has led to reception's neglect is more mundane: logistically, production is often such an enormous task that little energy is left to attend to reception. Developing EE vehicles (scripting, producing, disseminating) is no mean feat. While reception is very much an interest of mine and my colleagues in MARCH (a US Centers for Disease Control and Prevention project using radio serial drama; see Galavotti et al., 2005), I have to admit that the reception element of MARCH (the "reinforcement" component of this intervention) has received much less attention than it deserves.

One cannot overstate the fact that the outcomes of narrative interventions depend more on how stories are understood than on the intentions of those who generated them. Exploring the production/reception distinction from another angle, we are reminded that narratives are not only stories, they are interpretations. Meaning does not inhere in words or actions—it resides in the meaning that individuals apply to words and actions. The problem of polysemy—the fact that symbols are inherently subject to interpretation—is one that poses great challenges to narrative intervention. Of course, public health professionals are not in the business of generating stories for stories' sake; we want to intervene in an audience's narratives for a specific reason. As Slater argues, "Efforts must be extended to ensure that the message audiences take away from a story is the message its designers intend to convey" (2002, p. 160). Thus, an effective narrative intervention requires not only the production and dissemination of narratives, but also an intervention in the listener's sense-making processes to narrow the range of likely interpretations.

To recap this point, then, most public health professionals would agree that we ultimately are less interested in telling people good stories than we are in seeing that people put them to good use. As William Labov (1997) argues, "The most important data I have gathered on narrative is not drawn from the observation of speech production . . . but from the reactions of audiences to the narratives as I have retold them"(p. 395). Although we cannot control audience reaction to narrative, we can nonetheless design stories that prompt individuals to articulate their own experience and then encourage them to alter these articulations in ways that promote healthier behaviors. We also can take practical steps to narrow the range of interpretations a member of the public is likely to impose. Through a dialogic phase of a narrative intervention the possibility that the intervention may be wildly misconstrued or misapplied can be lessened. This phase might take the form of creating complementary activities in which audience members are invited to seek clarification or negotiate the meaning or relevance of a story to their own life. Naturally, such activities may be resource intensive and logistically demanding, but a narrative intervention that does not anticipate the need to shape reception seems theoretically untenable.

Messaging vs. Shifting Worldviews

Related to an emphasis on production, there is perhaps no construct in the study of communication more quintessential than that of "the message." From Marcus

Minucianus to Marshall McLuhan, communication experts in every field traditionally have thought in terms of packaging discrete propositions—messages—in ways that lead to effective exchange among people. The health communication field certainly is no exception, and behavior change campaigns, including narrative interventions such as EE, continue to stress message design and evaluate the effectiveness of how well messages "got across." This, I believe, hints at a fundamental way in which a better understanding of narrative would make a profound difference in current public health, including narrative, interventions.

Narratives are not sequences of isolated information; indeed the distinctive feature of narratives is their embeddedness in broader, cultural narratives and what Burke (1962) would call their complete "consubstantiality" with an individual's life. We *are* our stories. Furthermore, each of narrative's components—characters, discourse, plots, values, ruptures, and so on—only make sense in relation to one another. As Bruner (1986) argues, "The inseparability of character, setting and action must be deeply rooted in the nature of narrative thought. It is only with difficulty that we can conceive of each of them in isolation" (p. 39). Thus, intervention in narratives is rarely about the simple replacement of an inaccurate belief with a more accurate one. When narratives are successfully recast, the new meaning modifies not just a single fact, but also the fact's relationship to all the other facts in the narrative; it effects a change in one's worldview.

In practice, however, many in public health seem to view narrative formats as opportunities to plant bits of health information in a palatable way. Social marketing approaches, for instance, go to great lengths to craft the right messages for the right audiences. This is not to say that messaging plays no role in health communication and education, for, clearly, bits of information are sometimes all that is needed to effect behavioral change. But arguably, the best use to which narrative intervention might be put is similar to the aims of narrative therapy—to induce a significant shift in one's worldview and the way the person understands a range of significant relationships and reemplots past experience and future expectations.

What Does It Mean for a Narrative Intervention to "Work"?

If a narrative intervention has accompanying activities that reinforce key ideas that arise in the intervention (as I have proposed they should), those activities may have clear parameters and be amenable to evaluation, but the impact of narrative, in itself, is difficult to measure. According to Labov (1997), analysis of narrative "rarely allows us to prove anything.... It is essentially a hermeneutic study... [that traces] the transfer of information and experience in a way that deepens our own understandings of what language and social life are all about"(p.—). Echoing this, Green and Brock (2002) acknowledge that "The power of narratives has often appeared to be limitless, yet scientific understanding of how such power is exerted on individuals is in its infancy" (p. 315). Jeffrey Singer (2004) also concedes that narrative traditionally has been seen as "too humanities-oriented to be considered a part of scientific inquiry" (p. 437). So, how does an intervention technique whose effects are so utterly and unapologetically subjective defend itself to administrators and funding agencies with biomedical expectations of scientific rigor? The answer is, perhaps, poorly.

Generally speaking, theories of narrative suggest that story-based interventions may contribute to behavior change in very fundamental ways by:

1. helping individuals create cognitive and affective associations that influence "psychosocial" variables such as self-efficacy, outcome expectation, and risk perception;
2. suggesting ways in which reapplication of an earlier "technique" or problem-solving strategy can be successfully brought to bear on a novel situation (cf. Newell and Simon, 1972);
3. prompting a shift in situation comprehension whereby value hierarchies can be usefully rearranged (cf. Perleman, 1982) or by encouraging other framing effects (cf. Tversky & Kahneman, 1981; Sharf & Vanderford, 2003) in which a person's less risky sense of self can be tapped.

Thus, although we seek behavioral effects, narrative interventions are essentially cognitive interventions—stories contribute to change through memory and thought. But to demonstrate the impact of a narrative intervention on often private behaviors we must either black box the cognitive changes leading to behavioral change and look only at outcomes of narrative intervention in a modified stimulus-response manner (e.g., quasiexperimentally, cf. Vaughn, Rogers, Singhal, & Swalhe, 2000) or we have to look at the variation in narrative intervention's impact on individuals' cognition and extrapolate to both behavior and to broader populations. Neither option is ideal, yet the first is the one almost always taken. Understandably, perhaps, public health agencies are not going to press for understanding the process of narrative intervention as their priorities lie primarily in demonstrating behavioral impact regardless of how that impact is obtained.

The range of confounding variables that afflict much social science invariably makes narrative interventions, as *narrative* interventions, difficult to evaluate. First, of course, an individual's cognitive changes prompted by new narratives must work with social and structural change to result in behavior change. And as Sherry (1997) notes, the difficulty in teasing out the effects of narrative intervention such as a soap opera from other communication interventions in the environment is daunting. While some studies have argued that narrative interventions can have a multifold impact on behavior, such impact is necessarily diffuse and difficult to measure.

Even more problematically, perhaps, narrative interventions are ideally *designed* to blend into the cultural landscapes in which they are undertaken. By aligning themselves with individuals' processing of prior experience, new narratives effect subtle changes in the perceptions and appraisals that are prerequisite to behavior change. In fact, it may be that narrative interventions work best when they are least amenable to isolation and evaluation. So in arguing for EE, or any other narrative intervention, we currently are limited not only by a very incomplete understanding of how representation shapes behavior, but also by the nature of the intervention itself.

But if narrative interventions, by their very nature, confound traditional evaluation, on what basis can a good intervention be distinguished from a bad one? At present, the answer is largely speculative and draws from the constructivist and cognitive truisms presented in the course of this article. Narrative intervention, then, accentuates the essentially rhetorical nature of most communication evaluation: how do we make a persuasive argument? Determining the benefits of a narrative intervention always will be a matter of piecing together an array of empirical evidence into a theoretically sound argument directed toward a particular audience

(Perelman, 1982). Promising to play on the biomedical turf of control, randomization, experimentation, and replication is almost certainly a losing proposition.

Conclusion

Using stories psychotherapeutically in a clinical setting to help individuals change harmful patterns of behaviors is nothing new and, as I noted earlier, using stories in public health interventions is growing in popularity. But while the term "entertainment-education" is a perfectly good descriptor, it does not carry much explanatory weight nor does it help to "discipline" the field. I would argue that disciplinarity is important if behavioral interventions are to improve in any systematic manner as shared commonplaces, questions, methods, and debates permit new information and practices to be more easily disseminated and critiqued (Hoskin, 1993; Petraglia, 2003). While some rightly have pointed out that an excess of disciplinarity can lead to narrowly prescribed conventions of method and fixed theoretical frameworks (Messer-Davidow, Shumway, & Sylvan, 1993), the laissez-faire alternative is equally unproductive. The notion of narrative intervention, I believe, strikes a good balance between the two. It provides a disciplinary focus that is neither all-encompassing nor exclusionary.

The modest objective of this article, therefore, has been to suggest that recasting story-centered projects and strategies in terms of narrative intervention can open the door to a more practical and rigorous understanding of behavior change communication. Public health practitioners and researchers interested in narrative can turn to a rich literature for guidance and inspiration. Cultural theorists such as Burke, Roland Barthes, Paul Ricoeur, and Mikhail Bakhtin can supplement social scientific findings and help the field of public health investigate what it feels like to be in a story rather than merely tell a story. Burke's concept of *dramatism* explains how individuals understand and attempt to intervene in their environment by using language and stories as instruments of change. Both Barthes and Ricoeur examine the distinctiveness of narrative (as opposed to logical) reasoning, and Bakhtin's notion of *heteroglossia* seeks to explain the tensions that arise between our needs for language to both reflect individual experience and simultaneously connect us to our larger society.

In the social sciences as well, research in communication, linguistics, psychotherapy, anthropology, and other fields looking at narrative interventions can contribute to a more comprehensive picture of behavior change than we currently have available. Even if the nature of narrative intervention eludes the kind of scientism valued in biomedical areas of public health, continued work in areas of story grammar (Beck & McKoewn, 1981), narrativity and social memory (Middleton & Brown, 2005), transportation and absorption (Green & Brock, 2002), affective-cognitive interaction in stories (Haines, 2005), and other topics can contribute to the formation of a research agenda (cf. Singhal & Rogers, 2002) rather than just the accumulation of interesting experiences and ideas.

The very idea of "narrative intervention," then, may be a potentially disruptive, yet fundamental and productive, one for the field of public health communication and education. Although the phrase begs more questions than it currently answers, it suggests possibilities for a coherent articulation of theory and practice that, some have noted (Beck et al., 2004), we have lacked to date. More important, it provides

an entree into the ways in which public health audiences make sense of their behavior and their options.

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