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Practice guide to using narratives in assessments of older people

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The purpose of the guide is to help social workers and care managers reflect on the way they carry out assessments of older people, and improve the way they do so, by examining how they can use/make better use of narratives. We will be looking at how narrative can inform different types of assessment, primarily within a community-based setting. And we will also identify the use of narratives within more complex areas such as working with older people who lack mental capacity, are experiencing mental health issues, and who may be subject to risk or safeguarding.

What do we mean by ‘narrative’ and what is the relevance to social work with older people?

Within academia and professional life, the idea of ‘narrative’ is a post-modern concept and one which has now been embraced by almost every profession, such as law, medicine, nursing, education, the allied professions and, of course, social work. However, while more recently adopted in the care professions, the idea of narrative can be traced back as far as the 1960s. It is a cross-disciplinary concept, within the humanities and social sciences as well as traditional science and communication studies. You may hear people referring to the ‘narrative turn’ and this term indicates a larger ‘turn to language’ in the social sciences and the central significance of narrative within human interaction in relationships. Narrative is really “the daily stuff of social work”, given that social work practice is principally based on talk and interaction (Reissman and Quinney, 2005, p391). Hopefully by the end of this practice guide you will recognise that not only is narrative at the very heart of social work practice, but it is one of the most essential tools required by professionals needed to promote new paradigms of care as we move towards co-productive, more enabling, person-centred and inclusive approaches in our work with older people.

One might say that whatever a professional’s theoretical orientation and practical commitments, most will spend their working day telling stories. This guide aims to encourage you to focus on some of the nuances in how to engage with narrative when working with older people, and to consider some of the circumstances where narrative can be used to enhance assessment practice and to promote co-production and user involvement.

It is difficult to provide a simple clear definition of narrative that covers all of its applications, but within this guide we will review and focus on the definitions that are most purposeful for working with older people. We will consider how it differs from, or is similar to, life story work and other therapeutic approaches. We should be able to identify some of its potential applications for working with specific groups and circumstances involved in your work with older people.

How narrative is used in different contexts

Narrative is often seen as being synonymous with ‘story’. Those who have written about narrative in social work have not found a great deal of empirical evidence on its use within the social work practice environment (Reissman and Quinney, 2005; Baldwin, 2013), nor are

there many examples publicised by organisations meaning that there is scope for taking this forward as an enrichment tool for practice. The greatest use of narrative has occurred within research methodology, where it is used as a tool to collect data. Narrative analysis is also used as a method of interpreting service user and carer accounts within research in order to understand a phenomenon more deeply. For example, narrative analysis is used in mental health research by listening to service users' stories of recovery, to draw out and identify common themes from service users' experience, and to understand what and why some interventions are working. Kleinman (1988) suggests that once a service user's biography becomes part of their care, the possibility of dehumanising people within mental health and stripping them of what is unique about their mental ill health becomes less likely.

You will recognise how important this is within older people's services when you consider public enquiries such as the [report of Sir Robert Francis](#) (2013) into the failures in Mid-Staffordshire NHS hospital, which highlighted the lack of dignity and compassion in care stemming from ageism and the dehumanisation of older people highly dependent on both staff and their managers. The older people's own narratives and those of people directly caring for them were dominated by the priorities of senior management. Francis identified that it is not just frontline staff who need to be supported in seeking out patients' stories, to actively listen and act on what they hear, but that storytelling needs to happen at different levels in an organisation with staff who are emotionally resilient and encouraged to create an environment where there is a positive emotional 'tone' for the delivery of care.

Within care organisations, establishing an appropriate 'climate' or 'culture' is important to enable individuals to feel comfortable about raising issues that concern them and to be able to do this visibly and purposely. This should demonstrate to everyone, particularly service users, that the staff, managers, service or organisation is able to be responsive to the individual nature of people's concerns. This was clearly documented as an issue in Mid-Staffordshire (Francis, 2013). From a social work perspective, maintaining caring and compassion as core values and behaviours involves being active in promoting a range of diverse interactions between the people involved in an older person's care even outside your own personal relationship with service users and carers. Social workers commissioning and overseeing care arrangements have a role to play in using service users' narratives to promote a person-centred approach by communicating the individual's needs, preferences, culture and sense of purpose within their care plan.

Within health, there has been a movement towards trying to bring people back into touch with their service users in a very dynamic way by developing what is known as [Schwartz Center Rounds](#) (Kings Fund, 2014). This programme provides a place where people who don't usually talk about the heart of their direct work are willing to share their vulnerability and to question themselves using storytelling techniques. The programme provides an opportunity for dialogue that might not happen anywhere else in the hospital. This is a direct response to having less time with patients and a focus on diagnosis and treatment rather than the impact an illness can have on the patient and family. It acknowledges that many caregivers today are anxious, frustrated and under pressure – with no structured outlet for expressing their feelings and little preparation for the difficult communication issues that are an inevitable part of patient care. You can [listen to some of the people involved in Schwartz](#) and their experiences of the process and their recommendations to other professional colleagues.

Social work supervision may offer a similar mechanism for critical reflection and a recent systematic review of the literature and models of social work supervision (Carpenter et al, 2013) found that supervision tends to be more preoccupied with outcomes for workers and organisations than service users, and that it is very difficult to assess the impact of supervision on outcomes that matter to service users themselves. This is another area identified where a narrative approach may be relevant to improving social work practice.

We will be returning to the application of narrative approaches to understanding systematic abuse of older people later on and thinking about where the spaces might be for similar initiatives at a more local level, and how we might utilise the structures already in place to introduce or expand the use of narrative in older people's services.

Baldwin (2013) asserts that social work itself is a narrative activity. Everyday practice in assessments and support planning generates narrative by interacting through these activities with different structures. Examples include the use of narrative generated within decision-making panels in relation to allocating and prioritising resources; and in multi-disciplinary meetings, reviews and presentations. Other academics have given attention to the micro interactions and structures that shape 'stories' *about* social work activity and have focused on the analysis of social work's own storytelling; for example, in the debates about how bureaucracy and record keeping detracts social workers from engaging in more meaningful relationships with service users (White, 2009).

These different approaches to narrative analyses can help us understand how the day-to-day language and practices of social work draw on narratives to demonstrate professional values or to develop and shape its own discourse, and further to consider how this discourse affects social work's relationship with the public (BASW, 2013). Within older people's services, for example, increasing attention has been placed on outcome measures and in the standardisation of risk assessments in order to raise quality and safety in service delivery. However, the bottom line is that what is meaningful for each individual service user may not be measurable or reproducible. The role of the social worker in these situations is to advocate for an enrichment of the evaluation of what constitutes an effective service by drawing on a narrative approach which enables service users to develop a sense of their own outcomes and to have this valued within the organisation as a meaningful evaluation of the quality of support provided or performance of the service. An example of this approach has been developed in the Think Local Act Personal [Making it Real](#) programme, where some organisations have been developing a set of "progress markers" - written by real people and their carers to help organisations check their progress towards transforming adult social care in a way which reflects authentic personalisation.

At an organisational level, Making it Real is seeking solutions based on broader narratives of their local communities that actively plan to avoid or overcome crisis, and to focus on people within their natural environment or communities, rather than inside service and organisational boundaries. It also enables people to develop networks of support in their local communities and to increase community connections. The approach is based on assessment processes that take time to listen to a person's own voice, particularly those whose views are not easily heard, and to fully consider and understand the needs of older people when planning support and care to ensure that it is culturally sensitive and takes into

account their whole life, including physical, mental, emotional and spiritual needs. Most of this change is happening at the strategic level. For social workers, this involves generating 'I' statements or oral narratives in their direct work with service users to match these progress markers, such as: "I want to feel better emotionally"; "I want to get my hearing sorted so I can enjoy life more". You can [watch videos](#) of people talking about their experiences of the Making it Real approach. This is a good example of using people's narratives to develop services alongside assessment.

On the front line, social workers need to be aware of their own role in the construction of biography and how a situation is recorded and documented. Many referrals, for example, unfortunately provide little useful information (for example, 'not coping, in need of a care home'), which leaves a lot to be uncovered by the social worker such as the environment, conditions and circumstances which are shaping the experiences of the older person *assumed* to need longer-term care. The social worker has to enter the older person's world and positively participate in and observe their daily life, and try to suspend judgement about what that person's story is about so far. According to Floresch et al (2010), this process often leads to something being understood rather than solved, given that social work practice aims to identify individual, group, family or community problems, solutions, needs and strengths. You may then design interventions that help by starting with a careful analysis of where the service user 'is' and the service user's perspectives on the 'problem' or 'need', and therefore 'solution', and most importantly how the service user is connected to their environment. While this might all seem very obvious, there are tensions in having to also balance these approaches with the knowledge of how bureaucracy, rationalisation, and the whole complexity of purposes that organisations serve, with how effective you can be in determining the actual shape and content of service users' outcomes. This is commonly known as the 'theory to practice' gap.

While the written narrative may have a more limited impact outside the 'I' statements or insider account of the service user's situation, oral narratives can provide a balance in communicating issues and making connections with your own supervision or team meetings in order to influence how services support people more accurately. An example of improving and measuring outcomes for older people using a narrative inquiry has been illustrated in the [Making Safeguarding Personal](#) movement, which has developed a [toolkit](#) of alternative responses to managing and supporting people living with risk. The approach encourages practitioners to think about methods to engage older people with family group conferencing, peer support, building confidence, self-esteem and assertiveness, particularly where there may be coercion by those responsible for causing harm or having to make difficult decisions. Making Safeguarding Personal is a shift in culture and practice in response to what we now know about what makes safeguarding more or less effective from the perspective of the person being safeguarded. It is about having conversations with people about how we might respond in safeguarding situations in a way that enhances involvement, choice and control as well as improving quality of life, well-being and safety. It is about seeing people as experts in their own lives and working alongside them. It is about collecting information about the extent to which this shift has a positive impact on people's lives. It is a shift from a process supported by conversations to a series of conversations supported by a process (Lawson et al, 2014).

These changes to the culture of services for older people illustrate that the rediscovery of the emphasis on a personal story can provide a more reliable means of bringing back the personal and subjective experiences of an older person when using care and support services, particularly during periods of change.

In this guide we will use these broader examples to consider how the ideas of narrative help us explore and search for meaning when working with people in later life and, in turn, how these help us to promote participation and involvement of older people in communicating these. Some disciplines within gerontology, for example, view narratives as direct agents for achieving social change by drawing on humanistic and critical studies of ageing. They have turned to meaning-making in narratives to try to understand in greater depth the complexities and cultural experiences of growing old, so that strategies can be developed at all different levels (Ray et al, 2008). The sociologist Townsend (2006) coined the term 'structured dependency' to describe how retirement, poverty, institutionalism and restriction of domestic and community roles in later life have contributed to artificially structuring or deepening the dependency of older people. This theory of structured dependency comes from a conflict perspective, which asserts that older people have been 'forced' into a dependent role and explores how the very structures that are said to support older people can themselves bring about isolation and depression, which are then reinforced by the processes used to tackle these (such as assessment and care management). 'Deconstruction', a concept developed by critical theorists such as Foucault and Derrida, is an alternative means of analysing these assumptions and is often used in the social work literature on anti-discriminatory and anti-oppressive practice (Cocker and Hafford-Letchfield, 2014).

Deconstruction is a way of disturbing and overturning categories that we might ascribe to service users or communities by being more active in helping to interpret meanings on behalf of subordinated voices and perspectives. Examples might include the 'burden' of older people on society as a result of changing demography; or thinking about how far older people in poverty can really exercise 'choice' when designing support; and the ability of older people to learn in later life, even where they might have impairments to their health and mental health. Turney (2014, p168), in writing about the language of anti-oppressive practice in social work, reminds us that social work is an activity that is irreducibly dependent on language, whether in the form of talking, reading or writing – so that the way in which we use language really matters. She suggests that critical reading or reflexivity allows a broader range of 'texts' to come into view and to be treated as credible sources of knowledge for the profession. The most obvious of these are service users' own accounts or the accounts of those external bodies who seek to influence social work as referred to earlier. Challenging the knowledge hierarchy enables social workers to give serious consideration to texts that counter such views about the 'dependency' of older people which might also dominate social workers' perspectives, particularly as they are mostly dealing with people with very complex needs but who do not represent the whole picture painted by an ageing population. Acknowledging the contribution of older people, for example through their roles as volunteers, carers, advisors, mentors and active contributors to the national economy, can challenge dominant views.

Taking a narrative approach would perhaps offer an alternative way of deconstructing some of these processes and beliefs by actively considering issues such as ageism, its policy rhetoric and promoting the move away from structuring dependency in public services. This

would involve challenging the system itself through asking curious or courageous questions in situations where there are assumptions about older people, or perhaps why they have ended up in a particular situation rather than focusing on the problems that the older person faces as a result, which can individualise or pathologise the issues as well as the solutions. As just some examples, such questions might be framed as:

“I wonder what sort of opportunities Mrs X had to be able to manage her finances in the past.”

“Is her inability to cope based on insufficient support given or could we be more creative with the resources available?”

“What would be Mr X’s view of our views on his relationship with his carers?”

“How can I interest you in hearing what I am saying?”

“I am curious about what is preventing us from being able to imagine xx.”

‘I wonder if there is more to the meaning behind what s/he just said.’

“Is this the most significant part of our discussion or is there more?”

“Have we really tried all of the options available from X’s point of view?”

Narrative, storytelling and finding a voice

Not all talk and text are narratives. Some advocates of narrative such as Reissman (1993) suggest that features of narrative involve the development of a detailed plot and characters within communicative exchanges, and that storytelling is only one form employed. Reissman, for example, compares narrative to other forms of discourse such as reports, arguments and question and answer exchanges, and much of his work has involved analysing how social workers ‘talk’. Storytelling is one particular form of communication and this can be identified within written or in everyday conversation. Whichever aspect, all narrative forms provide key resources to enhance people’s ability to organise and talk about the world around them and to make sense of what we might think and do through the stories we tell. Storytelling is one of the cornerstones of narrative, which in turn involves defining and understanding the dominant story of the past and present and gives us the opportunity to develop or change the future story.

You can begin to see how all of this is useful in our work with those older people likely to have complex histories. Stories have also been identified as critical and central to the development of the sense of self. McAdams (1993, p11) suggested that “if I want to know myself, to gain insight into the meaning of my own life, then I too, must come to know my own story”. It may be that life itself is lived in storied form, with a sequence of events which unfold, not unlike the plot of a good story. Speaking/listening and reading/writing are more than merely passing information between people but are crucial aspects of constructing our personal and social worlds; for example, how do you or those you are working with know that they are being listened to?

Another imperative for using narrative in social work is that it can help to find our voice during difficult times. Narrative and storytelling involve deliberate engagement with some forms of communication in order to demonstrate that one is listening and hearing and taking action arising from communication. This may sound obvious but Rutten et al (2010) have asserted that the idea of promoting narrative approaches in social work is a reaction to a positivistic evidence-based paradigm and a dominant management discourse in the profession, although there is still minimal evidence on them gaining ground. Major reviews of social work practice (DCSF, 2009; Munro, 2011; BASW, 2014) have all highlighted the increasing subjection of social workers to more bureaucratic procedures and fixed outcomes.

There have been some turbulent changes accompanied with challenging debates about the true nature of social work and its purpose. However, the dominant discourse does not always have the voice of social work at its centre, or the voice of social work may not even be present if you consider some of the media reactions to serious case reviews. Further, social work is often expected to solve very complex problems faced by service users and communities within a context of great uncertainty. Many critiques of the response to these problems have been critical of the constant reforming of social work education and curriculum (Moriarty and Manthorpe, 2014) and of increasing control through increased policies and procedures (Bourn and Hafford-Letchfield, 2011) at the expense of creativity and humanistic skills (Leonard et al, 2012). Narrative may offer one vehicle to assist social work in this respect.

Weick (2000) has written about social work's increasing alliance with science and the challenges of using a scientific approach to describe what we do through emphasis on quantitative measures, particularly those embedded in performance management. Weick refers to this as social work's "second voice", meaning that we are now speaking from a place where "emotions are replaced with studied disinterest and complexity is resolved by narrowing the point of study" (p398). This voice "is framed by logic, rationality and rules, where right and might are more important than care and comfort and where winning eclipses warmth and worry" (Weick, 2000, p398). Our reliance on this voice, she suggests, has resulted in a "chasm of silence" that has acted to "mute the profession's collective wisdom and power" (Weick, 2000, p396). Weick asks that we clear our throats and speak in this voice of caring if we wish to describe adequately the "rich practice heritage that makes social work distinctively itself" (p398).

It could be argued that we have become more sophisticated at using this second voice. Weick stresses, however, that the first voice of social work *is* storytelling because this comes naturally from our practice wisdom and everyday communication and is the main conduit through which we relate to service users. The social work literature is rich in its assertion that the loss of this first voice and the attempt to hold on to it is in tension with government policy drivers and our local experiences of how this is played out in our local organisations. Initiatives that promote co-production are central to understanding the different voices when trying to work more collaboratively with service users.

Working with narratives can help us return to more experiential- and communication-based ways of working. Finding our own *first* voice can also help us develop concepts and insights for practice. One of the common ways of describing this is the use of practice wisdom, which

combines and integrates both objective and empirical experience with subjective or intuitive-phenomenological experience in the development of knowledge in social work. Klein and Bloom (1995) defined practice wisdom as a personal and value-driven system of knowledge that emerges out of the transaction between the phenomenological experience of the service users' situations and the use of scientific information. The result of this transaction is tentative, often unarticulated knowledge that forms the basis for on-the-spot practice hypotheses that enable progress to be made in the absence of certainty. Feedback from these practice hypotheses both strengthens practice skills and contributes to the articulation of knowledge in standard forms such as evaluation and theory development.

Narratives on older people

The Francis Report (2013) on the Mid-Staffordshire enquiry highlighted the absence of narratives at a strategic level in older people's services and a weak employee voice as parts of an organisational culture that led to a crisis and failure of care. His report laid bare the consequence of toxic, disengaged work cultures where the leadership, management and those responsible for governance lost sight of their strategic priorities or underlying narrative – which was to serve older people and their carers. These priorities were lost to the favouring of short-term ones. Secondly, the inquiry report demonstrated how the organisation had lost touch with some of the fundamental behaviours and integrity of what they are supposed to be there to do. Despite the espoused values of Mid-Staffordshire NHS Trust and with their focus elsewhere, the leadership lost touch with the employees on the front line and had stopped listening to their voices and views.

If you are interested in assessing the power of narratives in conveying strategic priorities, you can visit the site of the [Health Service Ombudsman](#) where the report [Care and compassion?](#) sets out an account of 10 investigations into complaints made in England about the standard of care provided to older people by the NHS. Of nearly 9,000 properly made complaints to the ombudsman about the NHS in 2009-10, 18% were about the care of older people, from which 226 cases were investigated, more than twice as many as for all other age groups put together. The issues highlighted in these stories — dignity, healthcare-associated infection, nutrition, discharge from hospital and personal care — featured significantly more often in complaints about the care of older people. The ombudsman collated the report in order to convey the stark contrast between the reality of care the older people received and the principles and values of the NHS.

The way in which the ombudsman chose to disseminate and share these situations is a powerful example of using narratives. You will find that there is no commentary needed in her report, which involves just a plain retelling of each patient's story, through which the ombudsman was able to “reveal an attitude – both personal and institutional – which fails to recognise the humanity and individuality of the people concerned and to respond to them with sensitivity, compassion and professionalism” (p2).

Within social care, we do not yet collate and learn from parallel inquiries such as serious case reviews, but we are beginning to be more systematic about learning from these social work failures in adults' services. For example, Manthorpe and Martineau (2010) undertook an analysis of 22 reports from serious case reviews on adult safeguarding and identified that the recommendations presented were more often described as bureaucratic rather than

narrative, and that more effort could be put into distilling the outcomes of serious case reviews as tools for learning across a wider audience.

Key features of narrative

Before going on to look at what it means to use narrative in your own social work practice with older people, we will firstly draw on the detailed work done by Baldwin (2013, p23-31), who has identified major features of narrative in social work. These markers might be useful to you when thinking about situations in your everyday practice and how narratives are present and influence social work with older people. Baldwin identified the following features:

Plot: the most crucial aspect of narrative as it conveys the creative sequencing of events, the basic information and goings-on in a story.

Characterisation: this lets us know what sort of people we are dealing with. In social work it is also a rhetorical device which assumes that everyone is thinking the same way about a person, group of persons or issue and the way in which they should be dealt with. When thinking about social work reports, for example, it is useful to think of how the subjects of those reports, are being characterised and portrayed, and who is responsible for attributing these portrayals.

Genre: this allows us to locate the story in a framework that feels familiar and from which we frame a response. The genre is a way of socialising individuals in the story into particular goals, identities, values and norms of the profession or organisation. It is a way of seeing and interpreting stories so that we can shape attitudes or expectations.

Point of view: these enable us to pay attention to what a narrator is saying, their motives and deciding who is doing the telling in the first place. Points of view lead us into constructing questions as to the validity and trustworthiness of the narrator or storyteller.

Rhetoric: this performs an important function in determining what is and what can be known and provides grounds for reliability. Rhetoric can be political or deliberative. As an example, Baldwin refers to the rhetorical features of the [National Dementia Strategy](#) (2009) and the way it argues for a particular course of action. Social workers may also engage in rhetoric when they seek to persuade others through their written and verbal reports, to present a course of action in a credible manner, and to seek agreement without putting forward any alternatives for the reader to consider.

Authorship: the concept of authorship is linked to that of rhetoric, as it does not exist independently of those for whom the text (written or verbal) is presented and may not be reliable or objective.

Readership: the readers will all bring with them their own attitudes, preconceptions and expectations to a text, which will affect how they interact with it, and this makes it an unpredictable activity.

To test out the presence of these characteristics, you are invited to look at one of the situations you are currently working with that concerns an older person. You could also consider the type and patterns of work that are currently taking place in your practice

environment in relation to issues that concern the work you are doing with older people as a group or service. The sorts of questions you may want to ask yourself or your team might include:

- What are the main 'plots' in your work or situation and do these go in a very similar way, or could there be a different plot or perhaps a twist which may result in alternative narratives being exposed?
- What roles or characters do we play in our day-to-day work or within our relationships and expectations from others? This may include the unquestioning assumptions about particular groups of older people and what they can or cannot achieve, or the day-to-day institutionalisation of practice where we are not able to provide flexibility around certain issues even though we know it makes sense.
- Are we being authentic in our assessments and support planning and can we imagine different possibilities with older people we work with? Are we able to create the sorts of spaces needed for them to tell us what they desire and need? Are we willing to take risks and experience the discomfort to work with different stories?
- How far are we able and willing to connect with older people's narratives in order to create an impetus for change? How does the rhetoric and reality cohere or conflict?

It is important to recognise that narratives are told in specific settings, and are co-constructed between the teller and listener, writer and reader, who together create the story because each brings a particular standpoint to it. These are important considerations within the dynamics of all the stakeholders involved in providing support. Stories may reveal personal, family or larger collectives including goals, ideals and cultural beliefs and many of these will help us to identify the strengths in a given situation making this a strengths-based approach. Hall and Powell (2011) remind us that culturally relevant information is often embedded in the stories service users tell which provide a more holistic, culturally sensitive, contextualised knowledge of clients, their families, and support networks. They distinguish between 'personal stories', which they say often include remembered chronologies of events, and 'identification stories', which may signify gender, race, class, relationship status and the cultural and political implications of older people's identities based on these aspects of self (Hall and Powell, 2011). Community Care Inform Adults' [practice guide on LGBT older people](#) is a good example of how significant the narrative is in challenging discrimination and oppression for a group of older people with significant historical significance and cultural backgrounds.

In summary, the theory of narrative identity postulates that individuals form an identity by integrating their life experiences into an internalised, evolving story of the self, which provides the individual with a sense of unity and purpose in life. Having a life narrative enables people to integrate their reconstructed past, perceived present and imagined future. As we saw from the structure offered by Baldwin earlier, narrative is a story that has characters, episodes, imagery, a setting, plots, themes, and often follows the traditional model of a story, having a beginning, middle and an end. Another example of narrative in older people's services at a strategic level can be seen in those developments following the implementation of the [Mental Capacity Act 2005](#) and Deprivation of Liberty Safeguards (DoLS) (2009), where there have been a number of legal judgements and case law based on the outcomes from 'best interest' assessments. These have brought many older people's narratives to the fore within institutionalised settings and encouraged those working with

them to respond in a more person-centred way with a more in-depth understanding of diversity, equality and human rights. John Leighton has closely examined this strand of practice and has [taken a look at DoLS judgments through a narrative lens](#). His narrative approach draws attention to the ways in which judgments are constructed in terms of presentation, persuasion, authorial presence and absent voices.

Narrative approaches and lifestory work

As you are reading this guide, you may be asking yourself about the differences between narrative approaches and lifestory work. There are many similarities to the two approaches given that some of the techniques, skills and approaches are common to both, but there are also significant differences. Lifestory work is often more focused on gathering information and artefacts about the person, their histories and interests, and involves producing a tangible output such as a lifestory book, storyboard or digital resources. This documentation of an individual's rich and varied history within lifestory work is essential to providing good quality person-centred care and enhancing their identity and personhood and staff understanding of these. Lifestory work is also used in psychotherapeutic approaches – for example, with people living with dementia – and alongside reminiscence has been shown to improve the mood, cognitive ability and well-being of those with mild to moderate dementia, as well as improve the relationship between the person with dementia and their carer(s). It can also be especially valuable when the person is moved to or between institutional settings (McKeown et al, 2006). Lifestory work is distinct from narrative as it emphasises using the lifestory in day-to-day care to improve communication, relationships and understanding of the individual's past life and in its orientation to the future (Nice/Scie, 2008).

The guidelines produced by NICE and SCIE

(<http://www.scie.org.uk/publications/misc/dementia/video.asp>) which give an example on storytelling in dementia care illustrate this by giving an example of an ex-serviceman living in a care home who constantly rattles the door and then cowers when he is approached. This could easily be labelled as challenging behaviour if it was not known that he spent a significant amount of time as a prisoner of war. A criticism of lifestory work is that there is no developed theory of change that underpins its use, particularly in the day-to-day care environment, and that there is little reporting of service users' and carers' views on their use.

Similarly, biography is another term associated with narrative and storytelling. Biography is a detailed description or account of a person's life which entails basic facts like education, work, relationships, and death combined with the portrayal of a subject's experience of these events. Unlike a profile or curriculum vitae, biographical approaches present a subject's lifestory, highlighting various aspects of their life, including intimate details of experience, and may include an analysis of the subject within their social or cultural context. As a research method, biographical research aims to collect and analyse a person's whole life or portion of a life, through the in-depth and unstructured interview, or sometimes reinforced by semi-structured interview or personal documents or from oral history, personal narrative, biography and autobiography, diaries, letters, memoranda and other materials. The central aim of biographical research is producing rich descriptions of persons or to conceptualise how persons and structures are interlinked (Zinn, 2004).

'Agency' is another important aspect of personal narratives and stems from the subjective awareness of a person that they are able to initiate, execute and control their own actions. Agency refers to the extent to which the narrator can be autonomous from their own perspective, and has the power to affect their own life. It includes an individual's disposition (sense of self-efficacy, sense of internal locus of control, motivation, aspiration and self-esteem) and resources (social, cultural, human capital), including community resources and individual membership of and activity in community/civic organisations which may enhance individual social and human capital and improve that individual's prospects. Promoting agency is linked to empowerment in social work.

However, the ability of people to act within, engage with and change social structures is subject to conditions of relative power and powerlessness. Walker (2005) reminds us that older people from professional and managerial occupations have more chances to construct and elaborate their own unique pattern of responses to ageing than those from semi-skilled and unskilled ones. Similarly, older women and ethnic minority elders experience poverty and social exclusion – two major constraints on agency - at higher rates than men and the white majority (Maynard et al, 2008). This illustrates the relationships between political economy, the distribution of power and the relationships in which power is exercised through agency and structure on successful ageing. You will start to see how narrative plays an important part in helping older people adapt to ageing.

Using narrative in your work with older people

Having looked at some of the features and theories about using narratives in social work, the remainder of this practice guide will go on to consider some key areas of social work with older people where a narrative approach may enrich your practice and the experience of the older person.

Using narrative in assessment

Narrative offers an approach that can access personal perspectives and subjective experiences in a framework that is meaningful to both older people and their carers in order to compare and contrast meaning in their personal accounts. While initial assessments are familiar to us, it is important to acknowledge that many older people approach assessment procedures with fear, uncertainty and a sense of vulnerability. These will be emphasised where there are mental health issues and dementia, where focusing assessment on cognitive changes can lead people to feel devalued and the process serves to intensify these feelings.

Writing from a clinical perspective, Mast (2012) suggests re-ordering the assessment interview by focusing on the person first, prior to a discussion of any problems which are focused on the medical or clinical symptoms that may already have been identified. Starting with a life-story method, he suggests, can enhance engagement of the older person in the assessment process and can assist in understanding the person through a richer exchange.

Such an approach may draw on life review techniques and prompts which can be used as part of the initial assessment; for example, by asking questions about the person's life to gain a longer-term view of them. In doing so, you can communicate an interest in the person while listening for information that is relevant to the original referral question and what you want to find out. This might include past mental health concerns, availability of social

support, and the person's preferred ways of spending time. This is advantageous in that using a reminiscence style approach can encourage a positive affect and can engage older people who might be resistant.

For example, instead of asking about whether they have ever experienced or been treated for depression, you might ask them to describe the happiest and unhappiest period of their life or some of the main difficulties they faced in their adult years. As the person responds, Mast (2012) suggests that we listen for themes related to mental health problems and follow up with more targeted questions. This approach helps to develop greater understanding as well as build trust and an alliance which engages the older person in the process, particularly where there is a tendency to under-report depressed mood.

Similarly, the quality of the caregiving relationship might be indirectly assessed through questions about the relationship, both now and in the past, by asking about the person's partner and relationship. Mast suggests using questions such as: "*What kind of person is your partner?*"; and "*On the whole, would you say you had a happy or an unhappy relationship?*". Finally, gaining a sense of how the person feels or thinks about their own ageing and any associated problems could be assessed by asking questions such as: "*What are the best/worst things about being the age you are now?*"; "*What do you hope will happen as you grow older?*"; "*What do you fear will happen as you grow older?*".

Needless to say, these need to be accompanied by skills such as attentive listening and the willingness to reflect back understandings, all core social work skills.

Mast (2012, p371) also reminds us of the importance of thinking further into the later stages of care – say, for example, where people develop mental capacity issues – and the extent to which professionals can integrate narratives into person-centred care plans and tailored interventions. These are important as issues arise in DoLS and advanced decision-making so that those supporting and caring for the older person can better understand the ways in which mental capacity may be affecting the person, how the person's values and preferences regarding care and living are developed from the information, and how they contribute towards better partnerships between the professional, person, and their family.

Patients from different cultures may express their experiences quite differently, injecting more or less emotion into the account. The account of pain, treatment or support may be more or less emotional or descriptive (Maynard et al, 2008) so that assessments of service users from different cultural backgrounds need to factor in what they have already learned about cultural traditions of explaining their situations. The ways of narrating situations needing care may be influenced by the cultural expectations of patients and their perceptions of the role they should play, as well as your role or those from the interprofessional team.

Price (2011) gives the example of an older man who narrates his failing sight, observing: "*Once, I was obsessed with telly, but you know the radio is far better than I realised; there have been treasures there that I missed over the years.*" At one level, a narrative such as this simply reports a greater reliance on the radio and difficulties with watching television. At a deeper level, however, the narrative might be about adaptability, finding an opportunity in

straitened circumstances. It might suggest something about what seems dignified to this man, finding integrity in coping, the use of different resources.

Working with loss, transition and change

As we saw in the earlier discussion on agency, adapting to ageing may involve discontinuities in personal identity resulting from later life losses, such as one's home and friends, and a decline in physical health or cognitive functioning. People moving into residential settings may feel particularly cut off from their previous lives. Narratives are also particularly important during transitional processes such as when one is moving into a new environment or entering long-term residential care (Walker, 2005). Despite some of the negative rhetoric around the passivity that older people demonstrate during transition, some research, including that by Reed and Roskell-Payton (1996), has suggested that older people are able to take an active role in transition, by constructing familiarity to build a bridge between their past and present life as opposed to focusing on the discontinuities that may result from moving into a different home.

This has highlighted the importance of working towards a sense of integrity regarding how transitions 'fit' into an individual's life story and more healthy transitions (McKeown et al, 2006) and can be internalised and reflected upon within an older person's life story. The use of narrative approaches helps to gain insights into an older person's experience and allows them to place these experiences into the context of their lives. For example, when talking about older people feeling at home in a residential or nursing home, this should encompass residents having continuity with their old life and routines, maintaining their personal identity through being encouraged to 'tell their stories', and being engaged in everyday activities going on around them.

Lifecourse theory has asserted that people in later life are in a period of loss, reflection and 'generativity' (Erikson, 1963). Encouraging older people to be in control of their own lives and to exercise agency is one way of challenging these discourses but to also bring critical realism, given that people in later life are likely to have faced multiple losses in different areas of their lives. Loss that is processed through storytelling and narration plays a pivotal role in promoting growth and change, given that loss can be a significant contributor to depression in later life (Atchley, 1997). Popular culture already attributes older people with tendencies towards storytelling (Mather and Carstensen, 2005), which can be associated with their accumulated experiences, authority on a particular issue through experience or wisdom, and expertise enhanced by time, either since significant events or from having more time on their hands. Embedded work through reminiscence, or life review within both assessment and the way in which services are provided, gives opportunities for older people to piece together the fabric of their lives, put past success, failure, and experience into perspective, and gain self-understanding and a sense of identity, values and beliefs (Erikson, 1963).

Encouraging older people to confront their losses and deal with death and death-related issues through their storytelling adds more power to the pure narration, and takes the storytelling to a deeper level. These approaches, however, require skill and experience and the ethical issues should always be at the fore of any discussion about loss and bereavement and referral to specialist providers where necessary. These might include asking the person how they cope with any deep emotional feelings, whether they have

spiritual or religious support or beliefs to turn to, and generally leaving enough time for them to process expressed emotion or asking whether you can contact anyone on their behalf.

It is always advisable for the professional to offer or carry out a follow up with the older person again soon after they have disclosed multiple or 'unresolved' bereavements. This is important to the older person that you demonstrate that they have been heard and to acknowledge further their feelings and that you are able to respond to any disclosure with concern and the knowledge that their disclosure may have made them more vulnerable. You may need to take preventative action such as by making a further referral to a counselling resource or by offering follow up support so that they are not left feeling emotionally vulnerable with nowhere to turn. Similarly, talking to people about bereavement is psychologically challenging and draining so it is important to debrief and share any burdens felt in supervision. Further encounters involving loss narratives should not be left on an emotionally raw note and the social worker should also consider their physical safety. Speck and Bennett (2005) maintain that there is a fundamental need for some bereaved people to tell their stories and that doing so appears to serve many functions, including remembrance for the person lost, respect and establishing self-identity. Through discussions of spirituality and personal growth, participants in their study demonstrated the ways in which their identities were shifting as a consequence of their bereavement experiences. The older person's identity became augmented to encompass that of the partner they lost and that augmentation was influenced by both internal and external resources (such as faith, spirituality, personal ideals and beliefs, alongside support from religious leaders and congregations, family and social networks).

At the same time, and in the face of overwhelming structural constraints, older people often attempt to maintain their identity by, for instance, trying to have a significant role in the family and keeping active in mind and body. In order to understand older people's experiences more holistically, we need to appreciate meaning, context and perspective of the person's situation. Because narrative is grounded in experience, is memorable and encourages reflection, it can be used to generate new hypotheses about why a person may not engage or is refusing support. Narrative is therefore useful as a way of exploring factors that influence decision- and choice-making processes when using or anticipating the use of care services. For example, narratives can provide insights into the effects of culture and history on individuals' views of their situation and care.

McKevitt et al (2005) reveal the extraordinary lengths that frail older people confined to home can go to in exercising identity-protecting agency by rejecting services. With the onset of disabilities, for example, engaging people in 'identity work' through a narrative approach helped the person readjust to new circumstances and maintain a sense of self-worth. This means moving beyond just sorting medical problems or practical care needs, but towards giving equal and, at times, priority attention to rebuilding self-esteem and a sense of self consistent with the revised social and family circumstances that come with increased disability and newly discovered needs for support. Their case study research suggested that, at times, practical responses may therefore need to take second place (McKevitt et al, 2005), which may go against the way in which we are asked to work in some assessment and care planning situations and be unrealistic.

McKevitt et al assert how important it is to spend time exploring the connections between social support and sense of self in older people through deliberately seeking to improve interaction between the older person in a time of crisis with others in their network. They found this encouraged the older person to be more amenable to using services in the long term. They suggested that this is because it maintains and strengthens identity and values built up across a whole lifetime, and this was important before they could start to confidently accept practical help and services.

Tetley et al (2009) undertook a study where they considered people's in-depth narratives to enable a better understanding of the factors that had influenced people's decision- and choice-making processes when using or contemplating the use of care services, particularly where older people were reluctant to accept help. These factors included:

- experiences of struggling to manage their everyday care needs;
- the role of personal factors (including resilience, alternative forms of support, and social networks);
- individual values and norms;
- the influence of biographical journeys, life history, faith, loneliness, and bereavement;
- individual responses, when faced with bureaucratic processes;
- the availability of acceptable service alternatives;
- system pressures constraining choice and control in decision making.

It is important to acknowledge that storytelling can be quite intimate, and facilitates older people re-experiencing the pain and loss of their earlier lives. You should be very aware of the sensitive nature of these discussions and the potential for emotional crisis, and therefore caution should be used in discussing and highlighting particular issues such as loss and awareness of other services where more specific skills are needed

Working with people with dementia

For people living with dementia and their carers, talk is an important area for understanding the ways that dementia and care are conceptualised. It has been established that older people with dementia use stories that can act as a means of maintaining a sense of self identity and constructing valid social identities in the face of social stigma and negative stereotypes often associated with dementia and its diagnosis (Surr, 2006; Sutton and Cheston, 1997). Attention to narrative agency is important in the study of meaning-making, and Baldwin (2013) emphasises the importance of identity, belonging and social relationships in engaging with 'narrative citizenship' among people with dementia. When the older person tells their own story, they are able to reflect on the meaning and significance of their experience, and through this construct and *reconstruct* their identities.

A study of paid and family care also demonstrated that carers use discourse and narrative to develop a sense of identity and meaning in their experiences of caring, constructing storylines of how they understand the nature of dementia and cope with the task of caring (Yeo et al, 2001). This involves attending to stories of important events and experiences that older people with dementia and their carers use to represent their interpretation of quality of life. A concern for subjective meanings in the context of life experiences provides a humanistic framework to understand the influences of ageing and dementia on people's expectations of life as an older person with dementia. The concept of an 'ordinary life' in the

social model of dementia attends to principles of social inclusion and citizenship through taking account of the social barriers imposed by society on older people with dementia. The desire among older people to maintain an 'ordinary' life has been established in empirical research (Godfrey et al, 2004).

In framing their lives as ordinary, older people with dementia resist their devalued social status as different and out of the ordinary. Being able to frame life as ordinary and normal is an important theme that also recurs in the narratives of the carers. Establishing life as ordinary is fundamental for older people with dementia to find meaning in life and for carers to represent a person's life as meaningful.

Using the arts to work with older people's narratives in group settings – some practice examples

In my own work with people with dementia, I have used narrative to promote their engagement by drawing on arts-based methods such as comedy and drama, which provide different methods to enhance the communication abilities of people with dementia as well as our own sensitivity, capacity and willingness to respond.

Kitwood (1997) established a vision for a culture of dementia care where language, environment, positive person work and human values are able to come together in order to facilitate opportunities for personal growth to flourish, given that people with dementia may be less able to respond to more conventional methods of engagement with services. Within some care settings, person-led approaches are often challenged by time constraints, limited resources and the need for staff who are well trained and committed to person-centred approaches. It is also important to draw on different methods to enhance interactions which may help to extend our practical and theoretical understanding of how the complex interplay of social, health, biographical and interpersonal factors contribute to the concept of 'selfhood'. Kitwood (1997, p119) asserted that being 'present' with and for the other person with dementia is fundamental to successful interaction. This includes letting go of the drive 'to do' towards focusing more on 'being' with people in creative, flexible, compassionate and responsive ways.

Adopting more positive discourses and imagery also helps the public perception and professionals to re-conceptualise dementia in a way which is empathic, and based on the strengths and capabilities of people living with it. It is purported that the arts provide one method to help promote social inclusion and well-being within dementia care, although there is a need for more systematic research into the efficacy of particular initiatives or programmes (Clark et al, 2010). Employing humour and laughter as one of these initiatives may appear to be risky at first sight. Masumoto (2009) has identified humour as a linguistic device used by older people as a way of mitigating the force sometimes felt against them, and to lighten the seriousness of a topic as well as to solicit empathy. Her research, which was based in Japan, drew on linguistic analysis (Matsumoto, 2007, 2009) to illustrate that not only can humorous narratives be used to break taboos around difficult subjects, but they can also defy and subvert the socially given image of older people being weak and depressed.

Likewise, Daminakis and Marzarli (2011) asserted that within an inter-personal context, expressing and appreciating humour contributes to sustaining positive social connections.

Their own research with older people demonstrated that the use of authentic humour and being able to laugh at oneself and life's uncontrollable circumstances appeared to support a positive sense of self, and was adaptive for coping with the inevitable losses that accompany the ageing process. According to Martin (2007), humour that is self-enhanced can be beneficial for people living with dementia, and corresponds with the ability to form a positive, optimistic outlook on life, despite the presence of enduring or immediate stressors. Martin referred particularly to the concept of affiliative humour, including tolerance and acceptance of both oneself and others, and its benevolent nature. They make the distinction of what they term as "self-defeating humour", where making jokes about oneself or allowing others to make one a butt of the jokes is used to gain acceptance. Furthermore, the utilisation of humour demonstrates an underlying recognition that the paradoxical aspects of life can contribute to a sense of wholeness and personal meaning through the life course (Damianakis and Marziali, 2011).

Within care settings, some physical benefits of humour and laughter on health and well-being have been demonstrated (Martin, 2007). Berk (2001), for example, notes its benefits in increasing muscle relaxation, improved breathing, and circulation, the decrease in stress hormones and a measurable increase in the immune system's defences. You may find these ideas controversial but narrative approaches are more likely to bring out these issues in a more natural way if we are willing to allow them to surface. You can read about the project I was involved with in more detail by [downloading the full project report](#). I have also addressed some of the ethical issues involved in using comedy with older people. This not only proved to be a powerful therapeutic device but also helped in the management of stress and sharing the burden, as well as in validating personal experiences of individuals whose autonomy, ability, choice and self-esteem is often lowered. Working through the narratives of individuals and groups of people also contributed towards a more positive climate in the care setting where the project took place, and older people were able to reflect on their 'care' environment with a sense of playfulness, which in turn enabled any problems to be more easily communicated.

Earlier I suggested that narrative can provide a vehicle for social change given that individual and collective narratives are closely intertwined and situated in a social-cultural context and provide the basis for social movements. We have seen this in the disability movement, for example. In relation to older people there are a great many opportunities to use narrative approaches in group settings. Davis-Berman and Berman (1998), for example, have used lifestories with small experiential groups of older people as a therapeutic tool. A number of providers, particularly through social enterprises and the third sector, have used the arts and humanities to express and explore narratives. Importantly, stories can be also be rewritten, and service users encouraged to develop an alternative story which provides a vehicle for hope and change given that this process invites service users to be involved in any editing and revision of their own stories.

Another example of using narratives and storytelling in residential care can be seen in the work of [Learning for the Fourth Age](#) (L4A) (for more information, [watch this video](#) of L4A's SPECS project). L4A is an organisation that works with older people through the provision of learning partnerships in which older people are matched to a learning mentor. Together they co-create learning activities that build on the older person's specific interests and which often provide a link to the person's past interests or help them overcome difficult circumstances by

learning new ones. The SPECS project encouraged older people to make short films about their lives which were then compiled into a documentary. Participants were involved in the editing process, learning a number of new skills along the way. Watch the video, which is just under 30 minutes, using what you have learned so far about narrative to see if you can recognise any features of narrative and to evaluate its effect on any new perspectives either on your own practice or in your team and service. For example, what might be the implications for supporting people entering long-term care or adjusting to their new environments?

Film-making or digital storytelling skills can be easily learned or tapped into when working with older people, given the increasing use of technology and accessible devices available in everyday practice. I have used digital storytelling to bring the voices of older people from minority groups into the classroom, such as migrant women who are ageing in the UK. Working with photographs and recording their own story through a digital recorder, the women were able to pose questions about how professionals could help them that may feel more challenging if asked face to face.

Making Safeguarding Personal – the role of narrative for improving outcomes

Earlier, we acknowledged the potential of narrative in rewriting stories and gaining control. Making Safeguarding Personal is an initiative that engages with narrative in order to promote better outcomes for people subject to adult safeguarding and in a more collaborative way. Making Safeguarding Personal (Lawson et al, 2014) is a shift in culture and practice in response to what we now know about what makes safeguarding more or less effective from the perspective of the person being safeguarded. It is about having conversations with people about how we might respond in safeguarding situations in a way that enhances involvement, choice and control as well as improving quality of life, well-being and safety. It is about seeing people as experts in their own lives and working alongside them. It is about collecting information about the extent to which this shift has a positive impact on people's lives. It is a shift from a process supported by conversations to a series of conversations supported by a process (Lawson et al, 2014). While this is not strictly a narrative approach, narrative plays a significant part in the approach to making safeguarding personal.

Lawson et al (2014) found that without a person-centred approach:

- While they appreciate the work of individual staff, people tend to feel driven through a process in safeguarding. At best they are involved rather than in control; at worst they are lucky if they are kept informed about what professionals are doing.
- Some people want access to some form of justice or resolution, such as through criminal or civil law, or restorative justice, or through knowing that some form of disciplinary or other action has been taken. They may feel disappointed or let down if this does not happen.
- Some people have no wish for any formal proceedings to be pursued and may be distressed when this happens without their knowledge or agreement.
- What we have monitored as outputs have tended to centre on such things as decisions about whether abuse was substantiated or not and what was done as a result: often additional services or monitoring.
- While most people do want to be safer, other things may be as, or more, important: maintaining relationships is an obvious one. We know from a national prevalence study (Mowlam et al, 2007) that: "Where people have been subjected to financial abuse,

respondents commonly viewed the financial loss to be less significant than the emotional and psychological impacts. For example, respondents could suffer low self-esteem and blame themselves for having 'let' themselves be taken advantage of. Service users said that they wanted to be listened to and to make choices and not to be treated like children. Their experience of how it felt throughout safeguarding intervention was as important as the end outcomes."

Drawing on narratives in safeguarding work will therefore lead you to consider:

- The quality and effectiveness of communication with people; how you will work with them and how they can participate in exploring the options and making decisions.
- The skills needed to facilitate conversations with people to find out what they want to achieve and, from their perspective, how best to go about this. Engage with best interests' decision-making in this context to achieve this where a person lacks capacity, perhaps through advocates/best interests assessors.
- How far your approach to helping people consider risk in their lives is both positive and person-centred.

Limitations of narrative in social work

You will appreciate that there are a number of limitations to using narrative in social work with older people. Firstly, there may be a lack of time and thus opportunities. Secondly, some of the assessment and care planning tools used may not lend themselves to a narrative approach, for example, standardised assessment forms. Thirdly, narrative approaches may lead to particular interventions where there may not be sufficient resources available. Meaningful participation is affected by a range of issues, including cultural divisions, language barriers, gender, ill health, time, and resources. However, making use of existing opportunities and structures is important, as the following case study illustrates.

Case study

George, a 90-year-old eastern European man, is referred to the hospital social work team following admission after a fall at home and a mild stroke. He has regained some of his mobility and is ready for discharge. He lives next door to his daughter, Mary, aged 70, in a housing association property. She maintains that she can manage but the staff are concerned that George was admitted in a neglected condition, with an unexplained weight loss which, according to investigations, does not have any underlying medical cause. The staff are concerned about his ability to cope and feel that George needs a care package to help him regain his independence.

The social worker, Yolanda, visits George on the ward and Mary is there. She notes that Mary constantly answers for George, who seems hardly engaged in what is happening. Mary says there is absolutely no need for social services to "waste their time with George particularly as they didn't give a jot before he came in and just look at the bloody state he had to get to before anyone did anything!" Yolanda has no opportunity to speak to George alone and decides not to insist on this on this first encounter. In discussion with her manager, Yolanda is reminded that the clock is ticking to expedite discharge within the regulations, and suggests that if the daughter is willing to cope then perhaps offer a carer's assessment and refer this back to the community team.

Yolanda discovers from her information gathering that George is seen by his GP as a bit of a 'charmer'. He had been a successful builder and liked to have a drink and there was a hint that there had been some 'altercations' in his marriage with Rizia (who died five years ago). The GP expresses concern about his daughter Mary's involvement and gives an opinion that she doesn't seem to have his best interests at heart, and said he was shocked to see the living conditions during a recent home visit resulting in George's admission. From the nursing staff, however, Yolanda learns that George is surly, rude and verbally aggressive to staff, including making discriminatory remarks, but can be on his best behaviour with the hospital doctors.

Yolanda is now concerned that the situation is more complex than she first suspects but does not have sufficient evidence to proceed with an assessment without the consent of George and Mary. She recognises the competing narratives; that of George, who can be a difficult older man, but is potentially vulnerable to abuse; and of Mary, who is refusing help but may experience a challenging relationship with her father.

Yolanda returns to the ward to test out the information she has gathered about the home circumstances. George is uncooperative and answers in monosyllables, and tells her: "Well, don't bother with me, I'm not bothered with that, nothing bothers me." He later laughs, saying "they should shoot us all old people". In her subsequent meeting with Mary she is met with an aggressive response, particularly when she presses for a home visit. Yolanda is now confronted with two people who are rude, aggressive or uncooperative and discusses this with her manager.

Yolanda's manager suggests that she writes a conciliatory letter acknowledging the feelings of frustration and lack of support and to arrange a phone call with Mary (particularly to reduce any risk of further abuse). Yolanda is surprised when Mary calls her and starts by apologising for what has happened and her general demeanour is one of being sad and resigned. By focusing on George's life history and asking questions about his previous strengths and life events, Yolanda finds out that there had been a very acrimonious relationship between him and his immediate family for almost 20 years. Mary talks about his problematic alcohol use, the hard life that her mother experienced as a result of them being isolated, and some occasional violence towards her and her siblings throughout their life. Yolanda learns that the other siblings have given up and moved away, and that, having come from Poland, there is little support in the local area. It also emerges that George had to leave Poland during the 1940s, having become homeless during the war. Mary admits that she hasn't been good to her father because of how angry she feels about his growing dependence on her, and has almost felt as if she was paying him back for her own miserable life. However, with the right questions, she is able to tell Yolanda that she feels sorry for her father and that she is also still experiencing intense bereavement for her mother, and she demonstrates insight and empathy from a number of perspectives.

Yolanda is able to agree some interim support for Mary so that she can have some space to try to sort out some of her own emotional needs and have some time with her partner who has been supporting her in the background.

Yolanda then talks to George about his daughter being unwell and, although reluctant, George agrees to accept a visit to assess his home situation. Yolanda is able to talk to George about the loss of his wife and George shares some of his regrets about their relationship and loss of his friends and networks. Yolanda is able to secure his agreement to explore how she could link him with a local Polish association and get some support with maximising his income. She also is able to facilitate a family meeting with Mary and her brother and a friend who George has not seen for a while, to agree a very limited programme of support from a local care agency and to find other ways of supporting him. This meeting had a strong focus on the loss of Rizia and there was a lot of talk of what she would have said or wanted for them all. Yolanda was able to pick up on these cues and find ways in which the different individuals connected or had a common tie. Yolanda also talked to the GP to see if George can be assessed for depression, picking up on some cues from George's expression of poor self-esteem.

Discussion

This situation could easily have been dealt with in a very surface way. Continuity of family life, despite its difficulties and risks to individuals, is important to older people. Although working under pressure in the hospital discharge situation, Yolanda was successful in picking up some cues in her routine enquiries and was active in offering opportunities to talk about life history and to support people in retaining a sense of self. It may have been easier to dismiss someone like George, who presents as an unpleasant person, and to take the narrative about Mary at face value. Narrative approaches are primarily concerned with using yourself to promote interaction and relationships both between social workers and service users and carers, but also between formal/informal carers and service users. It involves taking a curious stance and Yolanda was able to perhaps move a situation on which was likely to represent itself at a later date.

The narrating social work and narrating team

Talking about our service users, carers, and services is a learned and skilful part of our daily repertoire. Through our narration, we seek to describe our abilities and capabilities so that our practice can be 'seen' and established, particularly because the majority of the work that we do is not observed and our encounters with service users are only rendered through our own accounts (Pithouse, 1985, p78). Taylor and White (2000), for example, have looked at the rhetorical strategies that social workers employ to promote dominant forms of knowledge visible in their talk, and which often reflect broader societal or theoretical notions about older people. Between professionals, talk can also be used to display and reproduce and reinforce aspects of professional identities (Taylor and White, 2000, p121).

Reissman (2005) investigated how narration, argumentation and description is used by professionals to generate new insights but also in getting caught up in traps which prevent a deeper understanding of the situations they were dealing with and their own work, which can be detrimental for service users. For example, we might create accounts of care which describe what typically happens, what usually can be expected, what normally is done and the outcomes we expect, that is, rehabilitation, planned hospital discharge and person-centred planning. Price (2011) suggests that narratives such as these serve many functions, by helping to justify our intrusion into the lives of others (why we need to ask intimate questions), to reason why certain interventions may be necessary, and to determine the limits of what is professional. We may refer to 'rehabilitation' narrative, for example, with 'no

gain without pain' as a familiar phrase. Practitioners' narratives are sometimes taken for granted; they become the routine assumptions about how support is delivered, that which represents supportive and ethical practice. The narratives are built up through experience (that which works or seems possible), through education (that it has to be well ordered, organised or evidence based), and through team discussion ('how we arrange things here').

In more person-centred or co-productive care, the practitioner's narrative should work more closely with that of the service user. As we have seen, by giving attention to the unique experience of the individual way in which the person describes their circumstances, while also considering what is safe, will work and can realistically be provided, compromise can be sought when the practitioner and service user narratives do not coincide. Price (2011) considers the circumstances where service users' and practitioners' narratives run side by side and never interrelate that well. This may result in service users being labelled as 'uncooperative', or 'poorly motivated', and practitioners might quickly be considered 'aloof', 'insensitive' or 'obsessed with the system rather than with the service'. Practitioners' narratives that operate in technical or jargon terms are especially problematic. For example, 'a good outcome' needs to be translated into terms understood by the service user – how well you are likely to feel and are able to do what you enjoy.

Price suggests that you identify two or three examples of practitioners' narratives that you routinely use and briefly describe them. For example, you might have a narrative to describe the ways in which you assess an older person's needs in their own home. Jot these down and note whether you use technical or complex terms. Do you think these narratives are accessible to others, such as service users and carers?

Similarly, thinking about your practice today, have you identified any service users' narratives being used? Have you, for example, spotted ways in which a particular service user habitually conceives of his or her situation? If so, have these shaped the way that you negotiated care with them? Have you spoken to them about the way they are conceiving their situation, problems and needs?

Finally, to evaluate how you use narrative, at the next practical opportunity set aside time to examine the narrative being shared by a service user in your care. Use some of the issues you have been reading about in this guide to investigate the narrative. Once you have done this, produce a short summary of what you concluded and ask colleagues to check whether they have understood the person in the same way. Reflect on whether you have arrived at similar conclusions. If your evaluations differ, has discussion about the service user and their narrative helped you to attend more closely to their interests and needs?

Reissman (2005) makes a clear case for why social workers and students of social work should acquire skills in ethnographic and biographical research, narrative and interaction analysis in their work with service users by focusing on their life histories and life circumstances. He argues that learning to observe, analyse and write in a different manner is useful to counterbalance other challenges in social work which mitigate against them such as demands to turn around assessments and put in place arrangements which are not adequately matched to service users lifestyles, cultures or needs. Taylor and White also refer to the way in which practitioners themselves make sense of how they use and produce knowledge in day-to-day practice. Professional reflexivity requires that practitioners begin

listening more carefully to themselves, attending to their rhetoric of persuasion and their own constituting practices; that is, listening with a critical ear to their own sense-making and knowledge-making practices (Taylor and White, 2000).

We end this section with a case example of a narrative provided by Price (2011) who is writing from a nursing perspective:

Patient's narrative: Since my heart attack, I am still weak; this happened so suddenly, it came on without warning. The best way for me to cope is by limiting the work on my poor old heart. I'll take it easy until I'm stronger; that's the best way forward.

Practitioner's narrative: Inactivity after myocardial infarction increases the risk of further problems of several sorts, affecting not just the heart, but the skin, lungs and circulation more generally. Mentally, patients may give up and get stuck in the hospital, when acute care beds are needed by other patients.

Compromise narrative: Let's explore your fears about your heart and how ready it is to deal with some carefully planned exercise. What evidence will show you how fit your heart muscle is? We are monitoring your safety in these ways, so we hope that this will reassure you. Here are the benefits of becoming more mobile – they support your plan to remain as independent as possible.

Summary and conclusions

Rutten et al (2010) suggest that developing and enhancing your knowledge of rhetoric and being able to understand and interpret narratives can be beneficial for reflective practitioners. A focus on narratives does not need to replace all other perspectives and approaches in social work, but provides a different method and resource for improving assessment and interventions through a more conscious interpretation and evaluation of practical situations in a way that creates a critical and even liberating awareness of older people's real experiences and lives.

Being aware of and familiar with narrative approaches can offer social workers a method that will enrich their exchange with service users and carers, and facilitate more empowering and co-productive practice. This is not straightforward within some environments where there is emphasis on standardising assessments or where you may not have a lot of time to spend with service users or to get to know them over time. To make the case for its introduction or expansion, you may find the following useful:

- When discussing everyday referrals or in supervision, rather than moving to place the scenario in a category or towards resolving an issue, maintain a stance of curiosity which involves constantly asking questions which one does not genuinely know the answer to. Practice these questions so that they become a more natural part of your repertoire.
- Think about the principles behind the Schwartz Rounds referred to earlier – what would this look like in your team or service and is there a way in which you can use your experiences with service users to learn about your own narrative skills and knowledge in a supportive environment using principles of critical reflection?
- At case conferences and meetings about service users, use the principles of competing narratives described earlier to explore the presenting situations from the storytellers' perspectives. Ask explicit questions about 'what the story is' and whether there are alternative or mediating stories that need to be developed.

- Use imagery in your supervision or with service users. This may involve the sharing of significant photographs, talking about an item that feels important or significant to them, or describing a metaphor or colour in how they are feeling or to represent them in their current situation. This can be an aid to assessment outside of lineal or strategic questions more traditionally used to gather and interpret information.
- When recording and documenting service users' assessments and care plans, make some purposeful statements that encourage the reader to be curious about the situation and how their needs are understood and acted upon. For example, include more 'I' statements in the care plan and provide a clear sense of the individual's ability to contribute towards their own support, and some information about their experiences and strengths.

Discourse, narrative and ethnographic work causes us to pay closer attention to the interactional, social and cultural contexts in which professional judgements take place. This is an essential source of professional knowledge from our practice which is constructed in everyday life through ordinary communicative action. These approaches offer techniques in our assessment and intervention that can open up new possibilities to engage ethically with older people, and it appeals to the tacit dimension of our practice that is not always easy to articulate. This might be for a number of reasons such as time, our own willingness to engage and the support structures we work in. However, a narrative approach demonstrates that communication plays a key role in maintaining identity, through building and sustaining relationships and friendships and through participation in meaningful activities which are part of our everyday work and require us to make a shift to work differently.