

Narrative, Meaning Making and Context-Based Care: How to Realize Person-Centred Care

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Abstract

This case study illustrates the need for person-centred care. It postulates a central position for narrative in meaning making processes. Three social functions are discerned in the use of narrative. A narrative model deduced from the metaphor of the spinning top is proposed to be used by professionals in their contact with patients. It is been argued that there is a need for a context sensitive evidence-based practice in which circularity plays an important role. The context is found in the lifeworld, especially social interaction and the life story. Circularities is based on the recognition that both patients and professionals are agents who interact and that there should be reciprocity to some degree in order to realize a fruitful and therapeutic treatment outcome.

Keywords: Metaphore; Narrative; Person-centred care; Life story; Mental health nursing

Introduction

A disabling mental disease or disorder will often upset the lifeworld of a patient completely. He or she will have to give meaning to the disease or disorder and the consequences it has for daily life. The patient will wonder whether he/she is guilty of the disease by an unhealthy life style in some way. He may feel responsibility for falling short of his own or someone else's expectations. There may a threat of new crises with imminent loss of functioning. He or she will need courage and self-confidence to face his/her limitations. There will be mourning over the loss of perspective. Social contacts with relatives may have been changed due to being dependent on care. There may have been a violation of trust because of the patient's actions during a psychiatric crisis. Or more in general we see that relationships become non-reciprocal, the natural flow and give-and-take in a relationship is replaced by a unilateral caring-for attitude. Identifying oneself as a patient, or being identified as one by others, is as entering another world. The role of a patient can be a refuge where someone takes shelter and sometimes it is a place of exile or rather expulsion, enforced by others. The patient commutes between the world where he is a patient and the world of healthy and 'normal' people [1,2]. The concept of 'lifeworld' is important. Following Habermas Kunneman [3] compared the concept of lifeworld with the concept of 'systemworld', distinguishing the intersubjectivity and the communication of norms and values from the communication by way of purpose rationality and formalized codes, as is the case in economic rules and the exercise of rules and laws in hierarchical structures. In health care we have the standardized diagnostic labels and the approach that fits the uniqueness of this particular patient. Both are necessary. The one cannot with the other. Whereas lifeworld can stand for a collective phenomenon, in health care it is more often used to address the unique experiences of particular individuals. Hermeneutic phenomenological research into the life world of chronic ill may explore what it means for someone to have rheumatic arthritis for instance [4], how it influences daily life, affects social relations but also how one's self-image can be eroded showing how much effort it may take to maintain the integrity of one's identity.

The individuality of modern man is seen as a great asset. It is associated with autonomy and considered to belong to the private domain of a self that is strictly defined and delimited from the world around. This idea denies that experiencing one's identity always is dialogical by nature. How we experience ourselves is in fact an

instantiation of a discourse (conversation) that the individual entertains with himself and others in his environment. It is a discourse that aims at understanding oneself within the interaction with the world around and is related to the evolutionary necessity to (re-)act adequately upon what comes on our way. We have a need for legitimating our actions [5,6]. People tell stories (be it full-fledged stories, or anecdotes, puns, etc.) about what they experience and in this way they define their identity. Philosophers as Ricoeur [7] and MacIntyre [8] claim that stories are necessary to motivate actions and that it takes a community of other people to receive these stories and to respond to. Stories create an unity, lend coherence to experiences without life itself would be incomprehensible. They structure our experiences and give direction to life [9]. The degree of exchange between the told story and action in reality (how they influence each other) is a matter of discussion. MacIntyre [8] speaks about "human actions as enacted narratives". This could be interpreted as deterministic with people locked up in the script of their life story. The social-constructionist psychology takes a stand here and opposes this idea [5]. A narrative develops as the outcome of interaction between a narrator and his audience. It is all about discourse and conversation [10,11]. This notion matches best with a nursing care in which not the technical routine is at the center but the inter-human contact (person-centred care).

What is person-centredness? McCormack [12,13], one of the leading theorists for person-centredness stated: "Person-centredness is an approach to practice established through the formation and fostering of healthful relationships between all care providers, service users and others significant to them in their lives. It is underpinned by values of respect for persons, individual right to self determination, mutual respect and understanding. It is enabled by cultures of empowerment that foster continuous approaches to practice development." Other authors

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talk about patient-centredness and Patient-Centred Care (PCC), but 'person-centredness' is more accurate in its emphasis on personhood and the essential view that the person is more than a patient alone and should be approached as such. This is very much in line with holistic and humanistic nursing (Peplau, Travelbee, Watson and others).

The nurse and the patient are both present as *agents*. In a mutual process they both confirm or deny meanings presented by each of them. They continue this until a story can be constructed at which they reach consensus and that is accepted by both of them as 'true' and which can be the starting point for care actions [14,15]. We then speak of a relational narrative. The concept of relational narrative can be used to question dominant cultural narratives. More often than not our ideas about relationships, identity, health and illness curtail our potentiality and can be hostile to the full development of our faculties. Dominant cultural notions are easily seen as a matter of course and thus they make it easy for someone who is ill to identify himself with his disease or disorder. However, man is not his disease. His identity cannot be summed up as being a sufferer from a particular disease. The disease narrative based on symptomatology is one story about a person out of many. The illness and recovery narrative is another and tells the story of how it feels for the person it concerns. Instead of a person who is a problem someone becomes a person who has a health problem. It creates room for a different way of coping with health complaints [10,16].

Vignette

The use of metaphors

Ann is a young woman, diagnosed with a borderline personality disorder. She is an inpatient in a crisis unit of a mental health hospital. She grew up in a Christian-evangelical family. There is a history of emotional neglect. Ann is very demanding towards herself, which reflects the high expectations of her parents. At the same time she lacks self-confidence. She is hypersensitive for criticism from others. That has made her to break off her ballet training. She auto-mutilated herself and was suicidal. Taken in on the emergency ward things seemed to deteriorate. She hardly tolerates her stay on a closed ward. However she is so afraid of being responsible that she rather avoids responsibility. This situation elicits serious feelings of guilt that she cannot handle. She gets in a downward spiral. When, in a state of dissociation, she starts bumping her head against the wall so hard that severe injury can be expected she is secluded and fixated for short periods of time. Things get worse when she refuses to eat and drink, threatens to set herself on fire and the head bumping becomes a regular recurring thing. Treatment policy is to stick to upkeeping her autonomy and to take action only as irreversible health risks threaten.

During a day shift I take her out to the garden. In a bed of flowers small plants have come up. I point them out. Then it occurs to me that I can use the metaphor of the small vulnerable shoot of a plant to draw the parallel between the young shoot and her life with the potential of possibilities and growth or development. If she wants to give the shoot a chance to become a flower she will have to water it, but even if she does not, it will grow and flourish under oppression. She is somehow startled, but does not say a word when we return to the ward.

Then there is moment of change, a *turn* in her attitude and behavior. It started with her announcement that she would like to go to a friend that weekend. "Okay, fine," I said, "but show us then the coming days here on the ward that you can function without needing us to care for you." Subsequently she spills the beans, the fuse has gone and she ends

up in the seclusion room. Yet something goes on in her mind. The next day her parents came to visit her. They withdraw to her room together to pray together and ask God to help their daughter. After an hour or so, during which weeping and moaning was heard coming from her room, she came out. She is tranquil and tells me that she understood that God is with her. She can handle her life now. The auto-mutilation is over, she assures me. She got power and peace from God. She could not have done that by herself, she says. She was powerless, desperate, weak and sick. We nurses, we hear her with so much as scepticism. How fast will she fall back again in her symptomatic behavior? Still, our fear turns out without ground, because from that day on Ann succeeds in functioning normally and she does not auto-mutilate herself anymore.

Interpretation

Did God really hear her prayer for help? Or is it the context in which her parents literally went to their knees to pray with her enough for her to satisfy or repair her suffering from the emotional neglect in her youth for which she never had been able to blame them explicitly? Could she now at last retreat from her symptomatic behavior without loss of face because she introduced as a kind of Deus ex machina the power and support she received from an almighty God while she herself was little and weak as sinner and martyr at the same time? She simply could not have hit the new road that would lead her to growth and development on her own. That should have implied that she could have done that much earlier and that she must have played the fool then or did not want it for some reason. She needed a God to embrace the healthy behavior options we mirrored her with head erect. To do that she used, probably without consciously knowing, a dramatic turn of the story from the theatre. We might say that Ann used a cultural notion here to her own benefit.

Narrative as performance

The way people tell their stories can be studied as a performance, as we have seen with Ann [17-20]. How do people for instance use diction, silences, accents, raising their voice or whispering to underline their story? How do they accompany their story with gestures, mimics and other expressions of their body (for instance of pain or fear)? Nurses read these signs as part of their daily work and interpret their meaning. Stories are told in order to communicate. With our stories we take up positions as agents/actors in real life. Stories do not happen in a virtual world. How we act and interact is real. Life can be compared with an arena (a narrative clichee) where we, in order to survive, must be credible, thus must have welded our life into a narrative unity and where we put on narrative tools as circumstances may require. Our stories may vary widely. Variation reflects the diversity of social functions. Gergen [5] distinguishes three main functions that narrative has: it shows a regressive, stable or a progressive outcome (Table 1). Things in life may remain unchanged, reflecting stability. A positive change for the better is also possible. Or life can take a turn for the worse. In our modern society change is seen as a dynamic force and

Types of narrative	Outcome of the story	Function in social interaction
Stability	Essential values will remain intact.	Consolidation of relationships.
Progressive	Growth, more and better.	Inspire confidence.
Regressive	Distress and misfortune, disease. Become a victim.	Elicit sympathy, compassion and commitment; exonerate people from having failed in one way or another.

Table 1: Scheme of different kinds of narrative according to Gergen (1994).

is highly valued in individuals as personal growth. Therefore people may opt for a narrative in which they clothe their social relationships with the promise of increasing value: anything that becomes 'more' and 'better' in future. There are however also stories with a regressive character. They too have a clear function in social interaction between people. Stories of distress and misfortune often call forth sympathy, compassion and engagement in the audience. Someone who recounts how depressive he is, usually does not describe his mental state with the intention of giving some objective picture of how he feels but does so to position himself in the interaction with others. Regressive stories can elicit compassion and concern at the same time. They may exonerate the narrator from failure and guilt and put the responsibility elsewhere (attribution). In our culture being mentally ill is a diagnostic label that stands for a whole complex of social functions with which an individual is recognized as a category of persons to which a whole realm of rules applies, privileges and obligations or expectations how to behave.

Somatic diseases and mental illness are thus embedded in social and cultural codes, that regulate how others can deal with someone in daily life, but this may not always be for the better where it corrodes the mutuality and reciprocity in the social contact. Receiving care objectifies you as a patient who deserves an understanding attitude for not fulfilling the expectations of an agent responsible for his own action that otherwise would be the case.

A narrative model for ill persons

People feel the need not only to position themselves in a social context, but also in the history of their own lives (life story). There is a fundamental need for experiencing oneself as the same person who you were in the past, have become over the years and who you are now. Growth and development, but also stagnation and regression are fitted into the life story and sometimes they become connecting themes between the different periods in life. The life story must however remain credible when told. The sociologist Goffman [21] used the metaphor 'face' and 'the keeping of face' to denote this fundamental need for maintaining integrity. 'Face' consists of positive qualities that we attribute to ourselves. How can for instance a young woman who suffered from anorexia and who was treated for it for over a year in a specialized clinic, resume her life again and fit in her experiences with anorexia in her life story? People will ask her: who are you, what are you engaged in, what have you been doing in life? She asks herself the same questions. As long as she considers the period in which she was treated for anorexia as negative then that period will remain an isolated black chapter in the book of her life. Her life story does not fit with her experiences and therefore these cannot be fully integrated in her life. Dominant stories in our culture, the codes how men and women should behave and the standard norms for success and failure in society can hinder us to find and live our own authentic autobiographic story. It is therefore important that mental health nurses use a dynamic multi-dimensional model with which (dys-) functioning and how the patient sees herself can be explained integrally and diachronically. Which nursing model comes close to this aim? Jong [22] connected the self care model with the patient's self care needs and activities with the image of a top. The rotating top is a metaphor (Figure 1).

Man must give a turn to his life (spin the top) and to do that needs a balance between the social, somatic and psychic domains of his life. The metaphor of a top does justice to the dynamic character of the struggle for a meaningful life. A top can turn around quickly or more slowly and may even tumble over. Comparing the way someone goes through life to the course of the top then we can say that development, growth, but also stagnation and regression are as the climbing and going down

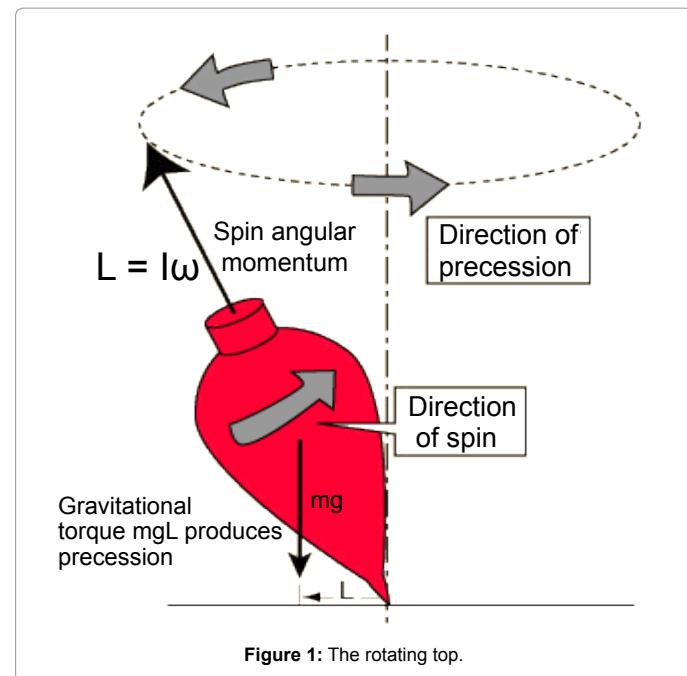


Figure 1: The rotating top.

of the top while spinning on a slanting surface, like the spiral in life that someone can go up or down. With a low orbital velocity someone can fall back in old patterns and routines of behavior from an earlier stage in life. The orbital velocity is also influenced by the condition of the subsoil (the environment). Obstacles and set-backs can make the top stagger. Illness and emotional damage are factors that influence our course through life, the movement and direction of the top. The idea of a spiral along which life is enacted is an apt metaphor to help people who got stuck in a linear or circular story ("everything is a repetition in my life") to realize that the spiral can widen and that we may encounter the same themes in our life, but all along in new variations and with the chance to learn from earlier experiences [23].

How nurses can use the metaphor of a spinning top and variations to it, as spiraling out of one's limitations and repetitive cycle of foredoomed failure, depends on context factors and individual aspects of the patient. Timing is important. The metaphor must fit. The connection can be found in key words that may come forward in a therapeutic contact and there must be an occasion as in the vignette story where the nurse and Ann walked in the garden (the image of a seedling presented itself naturally). Key words that can trigger the metaphor are: giving a *turn* to life, needing *balance*, life as a repetitive *cycle*, but when you learn from your actions there is a *widening perspective*. Nurses can carry a top with them when they are prepared to use metaphors and take it out during conversations to show what they mean. They will find out quickly enough if the metaphor strikes a note with the patient. When it does not then of course they must not pursue along this line of reasoning. It may help nurses to have a stock of metaphors at hand, or rather lying ready at the back of their mind. But it starts with awareness of the power of metaphor and being keen on finding them in communication.

Discussion and Conclusion

Nursing that aims at meeting narrative self-care needs will focus on the experience of illness and disorders and how its meaning for the life story and functioning in daily life is interpreted by the patient. The communication and expression of the meaning making process is

central. When there are issues and questions that transcend this focus and which are of a more spiritual or religious nature, then nurses should collaborate with a pastor or a spiritual councilor (or refer the patient to them). The focus for nurses is on the here-and-now and functioning in daily life. However, more often than not health issues have an existential aspect that transcends the sheer practical or pragmatic context. Meaning making is not something that we can leave to the pastor, because it involves the person as a psychosocial being and will influence how effective nursing advice and guidance can be, for instance in life style coaching [24].

In health care we witness a transition from a supply oriented care to a demand driven care that focuses much more on specific needs of target patient populations. The development of care path ways to manage a specific disease or clinical condition and that identifies at the outset what interventions are required and predicts the chronology of care and possibly the expected outcome of the treatment, meets with this call for person-centred care, but only half way. The approach is designed much more to ease the passage of the patient by coordinating care through the healthcare system than that it really facilitates personalized care. The Care Programme Approach, as it is also called, is still delivering standardized services that are preferably evidence-based and authorized by care guidelines. What we need however is *context-based* evidenc-based care. The recipient of care is a person: a *subject* (agent or actor) and not just an *object* for care. That means that we have to understand a patient's needs in the context of his life world and life story. The care professional needs to be *present* [25] as a whole person (not just performing from his role as a functionary), so he is a subject too. Monitoring quality of care that considers care a commodity, based on the idea of a market where consumers of care services and deliverers of care must come to an agreement, is far too narrow-minded. There is not one intervention that is the best. The linear intervention approach must be supplemented by an approach based on context and circularity. Circular meaning here that care is a process in which the outcome is not on beforehand known by the input of interventions, because there is a mutual influence of unique persons/subjects (the patient, the care professional and third party persons) and changing contexts. Without these person-centred care would not be possible.

References

1. Kleinman A (1988) *The Illness narratives. Suffering, healing & the human condition*. New York: Basic Books.
2. Frank AW (1995) *The wounded storyteller. Body, Illness and Ethics*, Chicago/London: The University of Chicago Press.
3. Kunneman H (1995) Narratieve individualiteit en normatieve professionaliteit. In: Baars J and Kal D (eds.) *Het uitzicht van Sisyphus. Maatschappelijke contexten van geestelijke (on)gezondheid*, pp: 61-84.
4. Bury M (1982) Chronic illness as biographical disruption. *Social Health Illn* 4: 167-182.
5. Gergen KJ (1994) Realities and relationships. *Soundings in social construction*. Cambridge, Massachusetts/ London: Harvard University Press.
6. Nijhof G (2000) *Levensverhalen. Over de methode van autobiografisch onderzoek in de sociologie*. Boom: Amsterdam.
7. Ricoeur P (1977) *The rule of metaphor*. London/New York: Routledge.
8. MacIntyre A (2001) The virtues, the unity of a human life, and the concept of a tradition. In: Hinchman LP, Hinchman SK (Eds.) *Memory, identity, community. The idea of narrative in the human sciences*. Albany: State University of New York Press, pp: 241-264.
9. Widdershoven GAM (1993) *The Story of life. Hermeneutic perspectives on the relationship between narrative and life history*. In: Josselson R, Lieblich A (eds.) *The narrative study of lives*. Thousand Oaks: Sage Publications, pp: 1-20. .
10. Boekhorst (2001) *Narratieve benaderingen in de (psycho)therapie: een richtingwijzer*. *Systeemtherapie* 3: 13.
11. Harden J (2000) Language, discourse and the chronotope: Applying literary theory to the narratives in health care. *J Adv Nurs* 31: 506-512.
12. McCormack B, McCance T (2010) Person-centred nursing. Theory and Practice. Oxford: Wiley-Blackwell.
13. McCormack B, Dewing J, McCance T (2011) Developing person-centred care: Addressing contextual challenges through practice development. *Online J Issues Nurs* 16: 3.
14. Gadow S (1999) Relational narrative: The postmodern turn in nursing ethics. *Sch Inq Nurs Pract* 13: 57-70.
15. Sakalys JA (2000) The political role of illness narratives. *J Adv Nurs* 31: 1469-1475.
16. Roberts GA (2000) Narrative and severe mental illness: What place do stories have in an evidence-based world? *Advances in Psychiatric Treatment* 6: 432-441.
17. Riessman CK (1990) Strategic uses of narrative in the presentation of self and illness: A research note. *Soc Sci Med* 30: 1195-1200.
18. Wortham S (2000) Interactional positioning and narrative self-construction. *Narrative Inquiry* 10: 81-110.
19. Peterson EE (2000) Narrative identity in a solo performance: Craig Gingrich-Philbrook's "The First Time". In: *Narrative inquiry* 10: 229-252.
20. Tappan MB (2000) Autobiography, meditated action and the development of moral identity. In: *Narrative inquiry* 10: 81-110.
21. Goffman E (1967) *Interaction ritual*. Hammondsworth: Penguin.
22. Jong de JHJ (1983) *Basiselementen voor de verpleegkundige theorie en praktijk*. Amsterdam: Elsevier.
23. Brockmeier J (2000) Autobiographical time. *Narrative Inquiry* 10: 51-73.
24. Sivast J (2013) Self-management and representation of reality in photo stories. *ANS Adv Nurs Sci* 36: 336-350.
25. Baart A (2004) *Een theorie van de presentie*. Utrecht (The Netherlands): Lemma.

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