Stories of Suffering, Stories of Strength: Narrative Influences in Family Nursing

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Narrative approaches are influencing family nursing practice. Narrative ideas, theory, and practices are currently seen directly in the practices of some advanced nurse practitioners, and postmodern influences are seen in the relational stances that many nurses assume with families. In this article, the authors describe narrative theory and practice, the current influence of narrative ideas in family nursing, and the possibilities for families and nurses that are created.

The stories of families are the fabric of family life. The stories that a family creates and lives by not only reflect but constitute and shape a family's beliefs, values, gender expectations, life experiences, and life meanings. In family nursing, families present with their stories. The giving and sharing of these stories are gifts. How nurses receive families' stories may have profound effects on nursing practice, on families, and on nurses themselves.

Storytelling, once demeaned by professionals, is becoming recognized as a valid representation of people's experience. Narrative therapy and narrative ideas have helped to change the way we think about stories. Stories are no longer seen as fantasy or fiction but as powerful and guiding representations of a family's past, present, and future lives. Stories reflect lived experiences of past events and shape the way future events will be lived. Stories speak of family interpretations and meanings and demonstrate how families live out the meanings. Narrative ideas acknowledge the influence of stories in mapping or shaping people's experiences and in blueprinting for future experience. Some stories constrain families by conscripting them into lives that are painful, and other stories heal suffering and open up possibilities for different and preferred lives.

There is a suggestion in some therapeutic approaches that the act of "storying" alone is sufficient to heal a family's suffering. The implication is that all that is required is for a family to recount their stories. It cannot be negated that there *is* implicit value and cathartic effect inherent in the process of telling "the story." Wright, Watson, and Bell (1996) emphasized the importance of families being encouraged to tell their illness narratives, or their own experience of illness in their lives, rather than telling only the medical narratives of their illness. Experiences and people are validated through the privileging of such narratives,

and yet, the idea of storying within a narrative paradigm is larger and more inclusive.

The concept and the practice of *storying* within the practices of a narrative approach do not ignore the value of the telling of the story and the healing embedded in being heard, but it has a different implication and therefore it travels a different path. Narrative approaches focus on the *deconstruction,* or exploration, of the source of problem stories that constitute the life of a family and recruit family members into lives of suffering. Problem stories are so powerful that they often marginalize family and individual stories of success and competency that are simultaneously present, yet unrecognized, and therefore unlived.

The intent of this discussion is to examine some of the ideas of narrative theory and to consider the contribution the ideas make to the practice of, and thinking within, the field of family nursing. In the same way that narrative practice acknowledges a belief in multiple realities, it is appropriate to identify the caveat that a narrative approach is but one way to work with and think about families. To claim anything different would be untrue to the philosophical foundations of narrative thought, as it would raise the status of a narrative approach above all others and hold it as the *only* truth (Amundson, 1994). Maturana (1988a) would call this (holding oneself as the only truth so that other realities are untrue and must change) an act of violence.

NARRATIVE AND THE CO-CONSTRUCTION OF PREFERRED STORIES

Using narrative as a guiding metaphor in the nursing of families moves us into thinking of the lives of families as being *multistoried.* It shifts us fundamentally into working collaboratively with families through their stories to “alleviate suffering” (Wright et al., 1996, p. 63) and live more fulfilling lives. Narrative theory finds influences from social constructionism, which guides us to envision the intersection between people’s personal realities and social, interpersonal, interactive realities or socially constructed realities (Freedman & Combs, 1996; Parry & Doan, 1994).

Postmodern ideas and second-order cybernetics set a foundational stage for the belief that there is no one objective reality. The realities of individual families and of individual nurses are equally valid and legitimate, and each reality influences the other. Nurses working with families do not stand outside the family system and make objective assessments; nurses affect, and are affected by, families.

Although postmodern thought invites us to think that there are multiple realities that are equally valid, it does not suggest that all realities are preferred or “anything goes” (Efran, Lukens, & Lukens, 1988, p. 33). We are connected to each other in ethical, social, and political ways. There is a belief within some segments of narrative practice that, although valid, realities are not necessarily

equally preferred or desirable (Freedman & Combs, 1996; White & Epston, 1990). There *are* preferred realities that reflect the ways people would rather be living their lives. Given choice or opportunity, families generally would not choose to live out a life of violence, abuse, or subjugation.

Realities are constituted through language (Freedman & Combs, 1996; Maturana & Varela, 1992) and expanded through stories. Family narratives organize and maintain certain realities while at the same tune censoring other realities (Parry, 1991). Preferred language used in narrative practice, such as "co-evolution and co-creation," reflects social constructionism. Nurses, influenced by the language, beliefs, and practices of postmodern therapeutic approaches, such as narrative, view family and individual problems as co-evolved, mutually agreed upon, and internalized "stories." The stories are the scripts of our lives and thereby dictate the way we view ourselves and relate to others.

Narrative ideas and practices have been brought to the foreground in the literature by authors such as Parry (1991), Parry and Doan (1994), White (1989, 1993), White and Epston (1989, 1990), Sandelowski (1991), Howard (1989, 1991), Tomm (1989), Freedman and Combs (1996), Madigan (1996), Vezeau (1994), and Zimmerman and Dickerson (1996). Basic to the assumptions of narrative practice is the belief that people are not problems; it is the problem (and the story about the problem) that is the problem (Freedman & Combs, 1996; White, 1989). Wright et al. (1996) have further specified that it is not only the problem, but the beliefs about the problem that are the problem. Within this philosophical stance, problems, which are socially constructed stories and beliefs, are seen as separate from families. Problems have lives of their own. Problems are not inherent in people; they are not fixed characteristics of people or relationships (White, 1989). The viewing of problems as separate from people is called externalization because people are invited to become "meta" to, or observers of, problem stories, their origins, and their influences. Externalization is not a technique, but rather a reflection of a narrative clinician's passionate belief and attitude about how human experience is organized and maintained.

The Story and Its Deconstruction

Because a narrative or story organizes, maintains, and constitutes the realities of families (Freedman & Combs, 1996), it is important to understand how people come to the stories that they embrace. A story is a map that extends through time (White & Epston, 1990). Stories within families are shaped by history and experienced within a cultural and gender context. Discourses were described by Freedman and Combs (1996) as dominant beliefs, practices, structures, and "taken for granted" realities within cultures that contain and maintain common values. The cultural and gender discourses within a society and within individual families, shape the stories that become the family.

Out of the many events of one's life, people and families choose certain specific

incidents that have some meaning to them. These events and meanings are used to understand past and present events and behaviors, and shape a story about one's self, life, relationships, and world. Once constructed, people continue to see events that fit with the guiding story, even when the story is not a preferred one (Zimmerman & Dickerson, 1993). Maturana (1988b) suggested that realities are determined by the explanatory paths we select. The chosen explanatory paths become our stories. Small stories and interpretations of meaning eventually become a "dominant story which is seen as 'true'; any new events which might conform to the story are added to it in an ongoing way" (Zimmerman & Dickerson, 1993, p.403). For some families, the dominant story might be one of strength, resiliency, and competency; for others, it might be one of despair and suffering.

To illustrate the construction of guiding life stories, we offer one of a young woman. In her early childhood, she imagined that she was musical. She loved music, and within the symphony of sounds in her own head, her singing voice was beautiful. Upon entering first grade, and failing her audition for the school choir (upon the grounds that she had "trouble holding a tune"), she chose to take that event/comment as the grounds for the creation of a story in her life that she was *not a* musical person. There were a number of other events she could have chosen, such as how quickly she learned to play the piano, or simply how music moved her, yet she privileged the voice that told her that she was tone deaf. As she grew older, other similar events, such as auditioning for the lead in the school musical and being rejected, added to her ongoing story of her life as being one without music. As the story became itself, it grew in influence to construct a life that was generally without the presence and enjoyment of music. The story was created by what she selected to see in her life; her life without music reinforced her story.

In a narrative approach, the story is privileged as *one* reality of a family's life. It is the frame for the "activity of meaning-making" (White, 1993) or the context for how we make sense of our world. Stories are not simply mirrors or reflections of life; people live their lives by their stories, and stories shape their lives (Freedman & Combs, 1996; White, 1993).

A story is told to a nurse by a family in a context of respect and trust. A nurse invites a story with respect, curiosity an appreciation of mystery, and a genuine desire to understand and learn. The nurse and the family can begin to deconstruct or unravel the story with an eye to the sources of its creation and the relationships or events that have maintained it. Within this deconstruction, the influence of the story in the life of family may become visible. Deconstruction was described by White (1993) as having to do with

> procedures that subvert taken-for-granted realities and practices: those so-called "truths" that are split off from the conditions and the context of their production; those disembodied ways of speaking that hide their biases and

> prejudices; and those familiar practices of self and of relationship that are subjugating of persons' lives. (p. 34)

White further specified that the process of deconstructing

> exoticize[s] the domestic.. . through the objectification of a familiar world. . . we might become more aware of the extent to which certain "modes of life and thought" shape our existence, and that we might then be in a position to choose to live by other "modes of life and thought." (p. 35)

Deconstruction, sometimes referred to as "unpacking," invites families to examine their stories and beliefs and to understand the sources of the stories and discover the influences. Stories and beliefs thereby become "external" to the family and open to scrutiny. Narrative therapists believe this process of "externalization" opens space for new possibilities and preferred narratives to arise.

Naming the Problem and the Plot

In the process of externalizing the problem, and as a means of objectifying the problem and not the person, the problem is named. The name is co-created between the clinician and the family, recognizing that it is most useful if the name is in the language of the family rather than in the languages of clinicians and nurses (Freedman & Combs, 1996; Parry & Doan, 1994). Families can be asked in a direct way to name the problem, with the question: "What do you call this problem you have been telling me about?" Problems that are less clear can be named by examining the "actions" of the problem: "What is it that seems to get in the way of you doing what you want to do?" or "What is it that seems to keep you more connected to your suffering than to your successes?" An example of naming the problem might be exemplified through a family with an adolescent daughter experiencing an eating disorder. They may name the problem "a fear-of-food career," which is very different from calling the problem "anorexia" or "an anorexic daughter." The family's name for the problem has benign interpretations, whereas the medical diagnosis and label is pathologizing in nature. When the name "fits" for the family, when it accurately describes the problem from their perspective, it is said to be "experience-near" or more relevant and true to the family's experience (White, 1989). The nurse may need to assist the *family* in abandoning medicalized and pathological descriptions, if this is how they have been lured into seeing the problem. If the definition of the problem changes over time, the name may change.

After the problem is named, the plot of the problem-supporting story can be identified. The plot describes ways that the problem has taken control over the family and gained influence on family life. The exploration of the plot and its influence serves to further objectify the problem. The nature of the problem, its characteristics, its sphere of influence, and how it interfaces with the life of the

family can be more clearly understood. Families can be asked about what strategies the problem employs to gain and maintain control in their lives. The plot of a “fear-of-food career” story, for example, might be that “fear” attempts to convince the young woman of her powerlessness over food. The adolescent’s growing isolation, avoidance of food, and weight loss may invite her family into believing that she *is* powerless and that it is *their* responsibility to change their daughter’s behaviors and choices, thus further undermining her sense of power and control over her life. The plot thickens, and the problem gains influence.

Unique Outcomes

Inherent within every story is the censorship of other stories (Parry 1991). Many problem-dominated stories come to nurses containing voices of overwhelming pain and suffering. Because no problem is a problem all of the time, the coexisting reality of periods (however brief) of coping, peace, and happiness go unrecognized. The family can become blind to their own strengths and resourcefulness in the face of problems. White (1989) wrote of uncovering unique outcomes to dominant and subjugating stories. Unique outcomes pave paths for new or alternate stories by contradicting and calling into question the dominant story that has become a family’s life. The clinician’s attention to, and meticulous exploration of, those times when families do not experience problems draws the family’s attention to a more preferred reality about themselves (i.e., “sometimes we are different /competent /problem free”).

Creating New Stories and Counterplots

White referred to the creation of a new story as a re-authoring of lives and relationships (White, 1989). Parry and Doan (1994) offered the language of story re-vision, identifying the clinician’s role as one of a “re-visionary editor.” The family is always considered the “expert and final authority” on the story (Parry & Doan, 1994, p. 120). Freedman and Combs (1996) suggested that as new stories are given birth, families can create alternative or counterplots to the old problem plot. White (1989) called this process the creation of “preferred stories and practices” or “counter-practices” (p. 54).

The preferred story or the counterplot is created out of the discovery of unique outcomes. In the example offered of the family of the young woman suffering from a “fear-of-food career,” an exploration of the ways they have escaped the influence of the problem in their lives would uncover the unique outcomes needed to start a new story Unique outcomes are often silently nested in the life of the family and are overlooked or overshadowed by the dominating presence of the problem and the problem story. Unique outcomes may not be seen as such until unearthed and identified in the clinical work. In our example, the young woman may be talking about being at a dinner party with her friends and enjoying a healthy meal. An inquiry might be made into how she understands that she was able to escape the influence of the problem and be around food without fear

dictating her leaving or avoiding eating. How was she able to defy the oppressive "job descriptions of her career"? As seeds for the new story are uncovered and illuminated, her influence over the problem becomes more visible and a counterplot begins to take shape.

Landscapes of Action and Consciousness

White (1993) and White and Epston (1990) referred to the "dual landscapes" of action and consciousness in which stories are situated. Landscapes of action are the sequencing of events and actions that unfold over time according to various plot lines. To situate a new counterplot in the existing problem-dominated landscape of action would entail inquiring into the details and sequence of the occurrence of unique behavioral and cognitive actions. The young woman at the dinner party might be asked to detail her experience of greater power over the problem in terms of who was there, how did she prepare herself for the party, what was she thinking before and during it, were there any moments of doubt, and how did she convince herself to go and to stay? How was she able to enjoy her meal and eat neither too much nor too little? The articulation and linking of these thoughts and events pave the way for exploration in the landscape of consciousness.

The landscape of consciousness is the making of meaning. Families are asked to examine their thoughts, intentions, desires, interpretations, beliefs, values, and motivations in an effort to reflect on the ramifications of the story that unfolded in the landscape of action (Freedman & Combs, 1996). These inquiries into meaning explore relationships between people, self, and problems. Our heroic young woman at the dinner party might be asked what this event said about her that she was able to attend, what might it say to someone else about her, and what does it say about her changing relationship with the problem?

Widening the Audience

Freedman and Combs (1996) noted the importance of strengthening the new story or "thickening the plot" by extending the audience for the new story and spreading the news of difference and change. The audience of an individual's new stories can be opened to the family and the audience of families can be broadened to extended families, friends, colleagues, and society at large. Other people can be invited to join in the new story, rather than co-opting with the old one. The echoes of old problem stories, if still carried by others, may serve as inadvertent invitations for people to abandon preferred stories and re-join with problem stories. Widening the audience strengthens, reinforces, enriches, and adds texture and text to the new story. Narrative practices explore many ways of opening space for a larger audience, circulating news of difference and change, and extending the new stories. Some of these include therapeutic letters, documents, certificates, ceremonies, leagues, invitations to others to attend

family meetings/sessions, and communication of change to other involved professionals.

NARRATIVE APPROACHES WITHIN FAMILY NURSING

There are advanced-practice nurses who are incorporating narrative ideas and practices in their clinical work with families (Wright et al., 1996). Nurses working in general nursing contexts with families are also influenced by narrative ideas. It is useful to make a distinction between narrative therapy and narrative ideas. Family nurses in generalist practice contexts may not have training as narrative therapists or advanced-practice clinicians. It is our belief, however, that the influence of narrative and other postmodern ideas can have a profound effect on the way we as nurses in many practice contexts view families, the way we view ourselves, and the way we practice.

Nursing practice can reflect narrative ideas *if* we believe that realities are socially constructed through relationship, *if* we believe that stories are the language of a family's equally legitimate reality, *if* we believe that it is not a person that is the problem, but problems that are problems, and *if* we believe in the potential of families and individuals to rewrite their problem stories. When we practice from these beliefs, then we are called upon to be different in our relationships with families. We are invited into being with families in ways that defy the traditional role of nurse as sole expert. We are called to think about families in respectful ways that acknowledge their wisdom and strengths. We challenge ourselves to think about our own stories, how they influence our relationships with families, and how they influence the stories we co-create with families. We are invited into working collaboratively with families in ways that acknowledge both the expertise of families and the expertise of nurses (Wright et al., 1996).

Nurses using the narrative metaphor to guide their practice are compelled to view families in a nonpathological light. We are invited to see problems as separate from families and to explore the reciprocal influence of the family on the problem and the problem on the family (Wright et al., 1996). We are gifted with hearing a family's story not as a truth, but as a demonstration of the way they have assigned meaning to their life. We are invited to hear the whispers of the preferred but marginalized stories and to help families give preferred stories loud and joyous voices. We have the opportunity to recognize and assist families in identifying unique outcomes or times when they have escaped the tyranny of the influence of problems in their lives. We are obligated to become political in our stands against oppressive discourses that promote violence, abuse, poverty and mental and physical illness as these are not preferred realities for human beings.

Postmodern ideas, applied to therapeutic relationships, operationalize the notion of caring. Nursing, as a profession, has fundamentally aligned itself with the concept of caring. As a concept, caring has been widely analyzed and advocated, but the primary focus of caring has been on the nurse's experience of

caring for clients. Less attention has been paid to whether the client experiences *caring from* the nurse. Maturana invites us to think of “love,” of caring, as the opening of space for the existence *of* another’s reality (Maturana & Varela, 1992). A postmodern relational stance opens space for *both* clients and nurses, and the result of nurses assuming this stance is that not only do nurses experience caring for clients, but clients experience feeling profoundly acknowledged, accepted, and cared for by the nurse. Reciprocally, nurses experience, recognize, and value caring *from* clients.

As nurses, we are driven to alleviate suffering (Wright et al., 1996). When families present with stories of pain, loss, and illness, they have often lost the other voices in their lives that speak of resourcefulness, fortitude, resiliency, competency, happiness, and wellness. Using the ideas of narrative as the source of our understandings and beliefs, nurses can help families in giving privilege not only to their stories of suffering but also to their stories of survival and strength.

SUMMARY

As nurses, we distinguish ourselves by the beliefs that we hold, by the language we use to conserve and honor our beliefs, and by the kinds of conversations we have within the relationships and contexts of our practices (Bell, 1996). We are immersed in very real human experiences of life and death, health and illness, and suffering and healing. Families entrust us with their stories and, in their offerings, they invite us into the passions of their lives. This is both a privilege and a responsibility.

Our stories are relational. They are the stories of families, the stories of nurses, and the stories of us, as nurses in families. All of our stories are acknowledged, authenticated, respected, and sometimes challenged by the beliefs, practices, and language embraced and demonstrated within a worldview of narrative.

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