

Using Ricoeur's notions on narrative interpretation as a resource in supporting person-centredness in health and social care

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Abstract

This article suggests a shift in focus from stories as verbal accounts to narrative interpretation of the every day as a resource for achieving person-centred health and social care. The aim is to explore Ricoeur's notion of narrative and action, as expressed in his arguments on a threefold mimesis process, using this as a grounding for the use of narration to achieve person-centredness in health and social care practice. This focus emerged from discussions on this matter at the IPONS conference in Gothenburg, 2021. Based on philosophical resources from Ricoeur's notions of narrative and action developed in his arguments on a threefold mimesis process, we propose a wider use of stories in health and social care practices. We suggest expanding from only focusing on verbal accounts to focusing on narrative as a human way to interpret and make sense of everyday life and circumstances and to communicate possible meanings. We discuss how such complementary focus can be a resource in getting patients involved and collaborating in their health and social care and thereby help develop person-centred practices.

KEYWORDS

narrative, person-centred care, Ricoeur

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1 | BACKGROUND

Stories matter in care. The ability of practitioners to elicit patients' stories or narratives and recognize these as a resource in health care practices is key to the recent development of person-centred practice (McCormack & McCance, 2017), person-centred care (Britten et al., 2020; Schenell et al., 2020), person-centred rehabilitation (Dean et al., 2012), and person-centred communication (Motschnig & Nykl, 2009; Öhlén et al., 2016). When health and social care practitioners elicit recollections from a person about their life and circumstances this is built on storied information. Stories also represent access to the lived experiences of the patient, which is often linked to an ambition to support the person and fulfil ambitions of participation and co-creation, as well as personal and communal agency. However, while many scholars and practitioners in health and social care practices extol the value of narrative and storied reasoning, we argue that, although important, the focus on eliciting stories still presents a limited understanding of what narrative is for humans in general, as well as for staff and patients in health and social care. For example, stories are not only individual accounts, but they are also embedded and constructed in social and cultural realms. Moreover, stories are closely connected to actions and practice, in that the meaning and interpretation of action and how to act unfolds in a narrative form.

Furthermore, the call for stories in health and social care co-exists with ambitions in policy mandates to organize and systematize care in ways that ensure standards of cost-effectiveness and logistic flow. However, such ambitions are not necessarily well tuned with narrative. One question, therefore, is how to focus on organization, control, and efficacy can be juxtaposed with narrative interpretative resources, characterized by open, evolving, and complex hermeneutic knowledge.

In this article, we will explore the above considerations by drawing on the French philosopher Ricoeur's (1913–2005) notions of narrative and action, developed in his arguments on a threefold mimesis process. By doing so, we suggest a possible philosophical grounding for the use of narrative as a resource supporting person-centredness in health and social care practice moving beyond eliciting patients' individual stories. Rather, we suggest a reading of stories based on Ricoeur's notions of narrative and action, sketching an understanding of how everyday interpretation takes intersubjective narrative forms and how such narrative interpretation communicates with biomedically based diagnostic information and organizational structures. The aim of this article, therefore, is to explore Ricoeur's notion of narrative and action, as expressed in his arguments on a threefold mimesis process, using this as a grounding for the use of narrative to achieve person-centredness in health and social care practice.

Firstly, we present Paul Ricoeur's notion of narrative and action and the three-fold mimesis process of interpretation as resources to support person centredness in health and social care practices. Next, we suggest how reflection on these resources provides understanding of how everyday meaning and evolving interpretations can

add to and function alongside standardized procedures of knowledge within these practices. Finally, we will reflect on the possibilities and challenges associated with these resources in relation to organizational aspects of care, as well as on the notion of co-creation and influence on the person/patient.

We (the individuals undertaking this enquiry) are collaborating for the development of narrative and story awareness in care practice for old people. In so doing, there is juxtapositioning and integration of perspectives from practice disciplines (occupational therapy, nursing, and social care), as well as theoretical disciplinary knowledge from ethics, anthropology, and sociology. Our focus was evoked by reflections from a workshop on the role of narrative and storytelling in care for older people (see Table 1) held at the IPONS conference "Personhood: philosophies, applications and critiques in healthcare" in Gothenburg (Josephsson et al., 2021). This both challenged, confirmed, and complemented our Ricoeur grounded perspective on narrative, serving to clarify our subsequent analysis.

In this article, we use the term "stories" for verbal accounts organized around an inherent plot. We use the term "narrative" for human interpretation taking storied form and which can involve both cognition, verbal accounts, and human actions (Josephsson et al., 2006).

1.1 | Narrative-in-action and Ricoeur's notion of three-fold mimesis

When the philosopher Ricoeur developed his theory of narrative as a basic resource for humans to understand themselves in everyday life he added to the shift in social sciences and health-related practices such as medical anthropology—a shift framed as the "narrative turn" (e.g., Mattingly, 1998). Several reasons for this shift have been presented, an obvious one being that health and social care are largely based on individual stories and these, therefore, become a relevant area to further knowledge (Bell & Hydén, 2017). Another reason is the role narrative has in theory on existential issues and meaning in everyday life. The philosopher Ricoeur has played a significant role in developing knowledge of how the meanings of everyday life are mediated through narrative forms (Knizek et al., 2021; Ricoeur, 1984). Particularly in medical anthropology and healthcare science, Ricoeur's notions of narrative and everyday life have been foregrounded as a resource for practices to take the perspective of the individual and their needs into account and to connect practices with relevance for the individual's everyday life (Kristensson Uggla, 2020).

Ricoeur's concept of narrative identifies human interpretation of oneself in social material and cultural situations as an acted and evolving process. Rather than focusing on narrative as "private cognitive activity," narrative is identified as a reciprocal interpretative process involving action and re-action—and the images these actions evoke. Thus, Ricoeur identifies interpretation in everyday life as an intersubjective process connecting the individual with emerging situations, identifying everyday interpretation as firmly embedded in

TABLE 1 Outline and major results of the work

Theme	The role of narrative and storytelling in supporting person-centeredness in care for older people
Method	Modified Delphi process to generate ideas
Trigger questions	What are the relation between narrative and action?
Theoretical resource	Ricoeur's reading of Aristotle and the threefold mimesis, and the interpretations thereof by Kristensson Uggla (1994) and Mattingly (1998), and narrative-in-action according to Alsaker, Bongaardt, Josephsson (2009)
Focus	Narrative as an acted dialogical meaning-making process; the acting person and the acted collaborative stories in everyday and practical care spaces, considering dialogue as a fundament for being a person connecting situated experience and material
Workshop Round 1: What do you mean with narrative?	<ul style="list-style-type: none"> • Narrative as cocreation in clinical settings, academia, and everyday life; to give spaces to peoples' voices and stories • Narrative (shared stories to create togetherness) to be regarded different from storytelling (my personal story) • Through narrative and meaning-making patients may take agency in for example their illness and clinical journeys, for example, visions for their future • Narrative as a way to create knowledge about meaning-making with people having disruptions in the life (e.g. medical conditions, trauma events) • Using narrative for data gathering • Stories as mosaic of meaning-making • Narrative intersecting with the body
What are the theoretical and philosophical resources you use as related to narrative?	<ul style="list-style-type: none"> • Maurice Merleau-Ponty • Paul Ricoeur • Emmanuel Levinas • Paul Freire • Rita Charon • Feminist epistemologies and the notion of epistemic injustice, including epistemic imperialism and how meaning is suppressed • Considering relationship between ontology and epistemology
Workshop Round 2: Tensions in using narratives in relation to person-centred practice	<ul style="list-style-type: none"> • Person-centeredness can be regarded "how practice already is and what we already do," and will not be regarded relevant if the notion of person-centred practice remains unpacked and the philosophical underpinnings does not become explained and concretized • Person-centeredness requires to work with stories and connect to shared stories, which is radically different from inviting the patient to share his/her story on one occasion • Rational knowledge discourses with for example standardizations and check-lists is privileged over narrative knowledge discourses and listening processes; this creates an epistemic imperialism and epistemic injustice where data gathering becomes more important than listening to the nuances in the stories. An example given was when the goals for the patient's rehabilitation are already set and time is not allocated to listen for the patient's own possible goals • The assumption that storytelling and listening to narratives take time and time constraints in practice settings put boundaries for time to be prioritized • The ethical issue of narratives and who the other is and what the other will demands from me as a person and as a professional; which kind of pandora box will open when we as professionals gives possibilities for the patient to share their stories

Note: The role of narrative and storytelling in supporting person-centeredness in care for older people held at the 24th IPONS Conference in 2021 (17 participants* in three groups). Major themes in the first group discussions (workshop Round 1) was shared with all participants, which facilitated the discussion and sharing reflections in the second group discussion (workshop Round 2). *The workshop's participants came from diverse academic disciplines and clinical backgrounds, and from several countries at two continents.

the individual's social, material and cultural contexts (Ricoeur, 1984; Ricoeur, 2007a). In so doing, Ricoeur does not ascribe a major difference in meaning between written and oral narratives, although the interpretation of texts provides a paradigm for interpreting action. Hence, a central dimension in Ricoeur's theory is the focus on

narrative and action as interrelated. Rather than separating human interpretation from the lived actions of everyday life, Ricoeur sees these as connected in evolving interpretative communication. In particular, our reception of Ricoeur's work on narrative and action is guided by work from Alsaker, Bongaardt, Josephsson (2009) on

“narrative-in-action” that is narrative as embedded in processes of action and interpretation. We identify this take on Ricoeur's theory as particularly relevant for health and social care, highlighting how narrative and action is related in everyday life situations and works generatively. This will be presented next.

1.2 | Narrative-in-action and the threefold mimesis process—Our reception of Ricoeur's notions

Ricoeur (1984) developed his notion of narrative and human life based on an interpretation of Aristotle's argument on mimesis, developed in his work on the function of tragedy. Aristotle's term “mimesis” has traditionally been translated as “imitation,” but Ricoeur has used it differently. Rather than seeing it as imitation, Ricoeur addresses how to understand the relationship between mimesis—expanded to be the evolving narrative interpretations of material humans perceive—and the world (Kristensson Ugglå, 1994; Mattingly, 1998; Ricoeur, 1984). Central to Ricoeur's adaptation is that human perception of the world and the every day is interwoven with acts of interpretation taking narrative forms. To explain how these interpretations work, Ricoeur opened up and developed layers in the concept of mimesis.

He argued that these interpretations are grounded firstly in Mimesis 1—material, such as cultural preunderstandings and praxis, together with language, body, material things, and so forth. In Mimesis 2, praxis and action are configured in possible situated plots, drawing on the moving material from Mimesis 1 but also testing out possibilities in response to situations problems and possibilities opened by the emerging situations. In Mimesis 3, the established plots are communicated with both concrete and interpreted dialogic material, which then shapes re-configurations of understanding and meaning-making processes. In the processes of mimesis, actions and activities create images and possible interpretations from the real-life context and set these in communication with existing interpretations. Through this creative interpretative mimetic process, individuals' views on existence, action, time, and other are elaborated upon and changed to make sense of the particular and evolving acting situations making up everyday life. Furthermore, this communicative interpretative mimetic process plays a significant role in guiding human action. So, when applied to health and social care practices, patients', and professionals' actions are guided by communicative interpretative mimetic processes (Alsaker & Ulfseth, 2017; Josephsson et al., 2006). When framing our reading of Ricoeur's mimetic process as narrative-in-action we move from focusing on eliciting stories as a resource in care to focusing on how to work together and set perspectives, such as patients and professionals in communication (Alsaker et al., 2009).

Given that Ricoeur argues that interpretations take storied forms, these everyday interpretations involve central functions of narrative, such as negotiating moral quests and what is a “possible good” in given situations and circumstances (Mattingly, 1998; Ricoeur, 2007b). Further, given that these interpretations are situated in the everyday

evolving social actions, they are not fixed individual traits or facts but rather fluid resources for communicating and developing oneself in the world together. Ricoeur also underlines the communicative functioning of these interpretations, setting materials and emerging interpretations of these in communication.

Drawing on Ricoeur's notion of the mimetic interpretative process, we have developed an approach to how narrative interpretation connects individuals with contexts, possibilities, and actions. While Ricoeur's theory of interpretation has been used in several fields (e.g., Kristensson Ugglå, 1994; Lindseth & Norberg, 2021) and with reference to his concept of narrative and narrativity (e.g., Frid et al., 2000; Wiklund-Gustin, 2010), the concept of mimesis, in particular, has been used to a lesser extent.

To summarize, we add to existing literature on the use of narrative in health and social care by suggesting a reading of Ricoeur's mimetic interpretative processes, highlighting how materials and circumstances are mediated and interpreted in everyday situations and actions (Alsaker et al., 2008). We identify these resources as opportunities from theoretical insights into how meaning can be established, negotiated, and developed in health and social care. Next follows how much reading of Ricoeur's theory on narrative and action can add theoretical resources to develop the use of narrative to promote person-centredness in health and social care. In particular, we will address the implications of our reasoning for structural aspects of care, as well as for the notion of co-creation and influence for the person/patient.

1.3 | Narrative as a resource to support influence and co-creation of health and social care

Health and social care guidelines call for the involvement of users in co-creating and participating in programs (Beresford, 2017). We argue that these ambitions need an elaborated grounding in how to achieve collaborative interpretations among patients and professionals, as well as theoretical resources to explain how lived experience can coexist with standardized measures and generic knowledge. In the following, we will address how a narrative-in-action approach offers possibilities to overcome the split between lived experience and generic knowledge.

Within existing practice ambitions, participation is sometimes operationalized as a notion of choice (e.g., Glasby, 2017). For example, the person fulfilling the criteria for receiving care can sometimes choose between different providers. Given that this limited understanding of choice seldom involves the receiver influencing how care is practiced, this way of adopting influence and participation has been criticized for being service- rather than person centred (Asaba et al., 2021).

As outlined above, Ricoeur's notion of narrative and action expressed in his arguments on a threefold mimesis process facilitates the connection of ambitions of co-creation and participation with the multifaceted character of everyday interpretation and this moves beyond static notions of choice. Rather than using a patient's narrative

as a source to access static wishes and ambitions, the evolving layers of mimesis show how everyday interpretations take the form of processes connecting wishes with existing structures, material, knowledge, and ideology (Mimesis 1). The actual meanings and interpretations take storied forms and are developed, expressed, and negotiated in everyday life (Mimesis 2). Finally, they are communicated and changed in collaborative situations, such as encounters with health and social care professionals and organizations (Mimesis 3). Taking these notions into account means a shift of focus from eliciting static stories from patients/clients to active, evolving creation of meanings and involvements involving the patient and the professionals as persons.

1.4 | Narrative as a resource to overcome structural barriers and achieve person centredness in health and social care

In contemporary health and social care, ensuring knowledge and evidence as a base is pertinent (Ellis, 2019) and mostly based on realistic philosophies and measures. At the same time, care guidelines emphasize that health and care need to be based on the patient's own understanding of her/his life issues. In other words, in health and social care, generic paradigmatic knowledge needs to be juxtaposed with the patient's own values and evolving interpretations. At present, we see little theoretical resource for how to set generic measures in relation to subjective interpretations. However, with his theory of Mimesis, Ricoeur had the ambition to bridge the subjective/objective divide (Kristensson Uggla, 1994). Applied to health and social care practices, narrative in action becomes a resource to enable different types of knowledge to coexist.

Foucault (1973) has shown how organizing the treatment of patients in the "clinic" enabled a *structured way of thinking: the clinical examination*, including standardized history-taking procedures to align with standardized diagnostic classifications. The focus shifted away from the person with an illness to the sickness and disease entity (Illich, 1977) and to determining signs of disease and its regulation. Health became defined as an absence of symptoms (Canguilhem, 2012).

Foucault's analysis helps us understand contemporary praxis of health and social care, where these central traits exert powerful forces on the organization and increasing specialization in ways that might reduce the person to the narrow status of the patient as a passive receiver of care.

However, alongside this clinical gaze we see a parallel focus with the individual at the core, based on humanistic values and practical wisdom. From our reasoning it follows that this parallel focus involves a situated and emerging understanding of the person including social and environmental material, as well as political and ideologically grounded perspectives. The notion of the person's gaze has been central in nursing, as well as practices such as occupational therapy, and thus influenced the language used in health and social care. Over time this has been expressed in phrases such as "seeing the whole person" and claims to hold a holistic view (which has not necessarily been explicated). In laws and guidelines, this humanistic language has

been operationalized in the use of words such as participation, person-centredness, promoting integrity, and preserving dignity, which require a narrative and storied knowledge.

We argue that when this humanistic and situated language is juxtaposed with the structural forms based on "the clinic," its meaning and practice might change and adjust to these structures and regulations. For example, even when a term such as person-centred care is used, the term "person" might still be influenced by an objectifying role rather than being situated in a person's multifaceted and evolving life experience. In this way, the clinical gaze might include, influence, and regulate the use of stories and narrative.

There are often well-motivated ambitions within these forms of regulating narrative knowledge, but since biomedical forms of knowledge and practice have greater socio-political power, narrative forms might get limited space. There is also a possibility for the transformation of the narrative into regulated information rather than into a space for emerging and multifaceted situated reasoning with the patient. Further, while giving voice through narrative elicitation may counteract epistemic injustices in healthcare practice, structural inequalities mean there is a need for more elaboration on when and why patients are attributed with credibility in their stories (Naldemirci et al., 2021).

An illustrative example of how the ambition to secure a knowledge base of health and social care can affect the use of narrative is reductionism implicit in digitalization and digitalized documentation systems. Although these ambitions have the desired consequences, such as more rapid and readily sharing access to needed information and portability across clinics/providers, they also risk running in tandem with static care processes. Following on from this there may be a risk of dehumanization in the wake of time constraints and fast-track processes with ready-made phrases and options. These procedures have a great impact on how concepts such as narrative and stories are used in care, even if the original ambition was to promote a more holistic view of health.

Based on Ricoeur's notion of narrative in action and the mimesis process, we propose another form of logic regarding the use of narrative in health and social care. Rather than being viewed as evidence of meanings inherent in patients, the narrative interpretations involving the person in need of care and professionals can be seen as a modality with which to set paradigmatic knowledge and structural forms of care in communication with lived interpretations of life circumstances and matters (Josephsson et al., 2006). Putting such possibilities into practice would mean actively giving space to interpretative dialogues and negotiations with patients. Ricoeur's arguments on a threefold mimesis process offer theoretical and practical resources to develop and provide grounding for such dialogic practices in health and social care.

1.5 | Reflection on how to go further with a narrative-in-action approach

At the IPONS conference workshop, participants highlighted a need to unpack theoretical groundings for the use of narrative in health

and social care (see Table 1). This article is one contribution to such efforts, and we will conclude by suggesting how to continue from here.

Our starting point is that the use of narrative in health and social care needs to be discussed and grounded to support a critically reflected practice. If we fail in this regard, there is a risk that a strong clinical gaze might take over and influence the narrative to be a measure of static decontextualized information rather than a resource for creating influence and person-centredness.

Our core suggestion is based on the philosophical reasoning from Ricoeur's notions of narrative and action, developed in his arguments on a threefold mimesis process. We propose a wider use of stories in health and social care practices framed as a narrative-in-action approach (Alsaker et al., 2009). We suggest expanding from focusing only on verbal accounts to narrative as a human intersubjective way of interpreting and making sense of everyday life and circumstances and communicating possible meanings. In doing so we identify possibilities for health and social care practitioners to take part in dialogues with patients, negotiate and develop meanings and thus make person-centredness in tune with evolving and changing circumstances.

We have argued how Ricoeur's theory on narrative in action and the threefold mimesis can be a resource for a resource for establishing generic facts needed in communication with lived experience and multifaceted and evolving interpretations. This way it can be a resource for professionals and organizations in health and social care in developing collaborations to achieve influence and involvement in health and social care together with patients and to collaboratively develop person-centred practices. It also presents an opportunity to overcome the split in health and social care practices between naturalistic measures and storied experiences, instead of creating room for a communicative space between patients and professionals.

It is important to note that taking a narrative-in-action approach to everyday interpretation in health and social care will not single-handedly eradicate problems or barriers to person-centredness. But we suggest it can help establish *trying out spaces* where patients and professionals can work together to lessen the divide between naturalistic and phenomenological knowing.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no new data were created or analyzed in this study.

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