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NARRATIVE INTERVIEWING: A CROSS-CULTURAL APPROACH FOR REHABILITATION PROFESSIONALS

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Abstract: Rehabilitation practitioners across a variety of clinical settings understand the importance of cultural sensitivity and rapport-building, in order to support client or patient engagement and follow-through with service plans for the attainment of clinical goals. The narrative interviewing technique is presented as a qualitative interview approach that is more in-depth than traditional interviews. It is a cross-culturally intrinsic method for exploring client concerns, promoting client reflection, deepening empathy for the client, and promoting deeper understanding of the client through storytelling – from intake through the process of termination. This platform is inherently person-centered and encourages opulent dialogue in a setting that is typically more prescribed.

Keywords: narrative, interviewing, rehabilitation, culture

Introduction

The act of telling stories precedes the act of writing stories. Storytelling is a tradition that is intimately intertwined with every culture (Carter-Black, 2017), as it is a method of sharing and keeping aspects of oneself – from both individualistic and collectivistic perspectives. In the realm of rehabilitation and human services, practitioners frequently encounter clients from diverse cultural backgrounds and are immediately faced with the responsibility and ethical commitment of building rapport, and establishing trust and common ground. This is a feat particularly difficult between a service provider and a client from a different country. Similarity in etiology beliefs supports positive perceptions of practitioner credibility, trustworthiness, counseling services, and future service provision (Chen & Mak, 2008). However, differences in cultural perspectives can likely lead to differences in beliefs about health conditions and their causation. The practitioner likely has much to learn about their client.

The traditional intake interview process is usually prescriptive, time-constrained, and structured with a series of close-ended questions that serve the purpose of obtaining introductory and demographic information (Martin, 2018). It can also be a time for a rehabilitation professional to provide an overview of services and clinical expectations. It is expected that the clinician leads and directs the conversation, determines its beginning and ending, and that the client waits passively to be asked or directed. For overloaded, time-constrained clinicians and unsure or apprehensive clients, this structure may be welcomed by both parties. In certain settings, this could possibly be the only feasible way to conduct initial meetings, due to various factors related to time, the credentials and skill level of the service provider, the goals of the agency, or the level of engagement of the client (Leahy, Chan, & Saunders, 2003). However, there may also be an opportunity to explore and engage with clients in ways that increase client and clinician engagement, as well as promote successful client outcomes. For the purposes of acknowledging a wide audience of readers within the realm of rehabilitation, the terms clinician, interviewer, and practitioner will be used interchangeably to represent rehabilitation professionals in a variety of clinical settings.

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Building rapport across cultures

Culture plays a central role in rehabilitation and human services (ACA, 2014; Akande, 2017a). The cultural background of the client, the cultural background of the clinician, and the culture of the setting within which services are being provided must all be acknowledged and addressed to ensure that ethical, and applicable treatment is being administered. The greater the differences in culture between the client and service provider, the likelier that barriers will exist in the rapport-building process. These differences can include gender, beliefs about gender roles, religion, language, sexual orientation, political affiliation, country of origin, and beliefs about health and disability. The culture of the setting within which services are being provided can include attitudes toward undocumented citizens, the availability of interpreters or Culture Brokers, or the geographic setting (i.e. rural, urban, suburban) (Jezewski & Sotnik, 2005).

Culture Brokering is a useful approach to bridging some of the gaps created when two different cultures meet. It is the process of connecting and mediating between two parties from different cultural backgrounds, with the intent of reaching a common goal or reducing conflict (Jezewski & Sotnik, 2005). This may or may not be a resource that every agency or practitioner will have access to. In some cases, particularly regarding clinical mental health counseling, having a third party involved might hinder the client's ability to wholly engage or open up about their feelings and experiences. However, the value of such dialogue should not be lost.

Narrative interviewing

Unlike traditional interviews (i.e. structured, semi-structured, unstructured), narrative interviewing is a counseling technique that encourages client stories or narratives, as rich, thorough responses to practitioner prompts. These prompts are open-ended questions or implied questions that are related to a larger topic that is of interest or concern to the client and warrants deeper exploration. This topic may or may not be the reason that the client is seeking services, but has presented itself as an issue that should be addressed in order to successfully proceed with the client's plan of service or attainment of clinical goals. For this reason, the overarching topic can also be identified by the clinician and presented to the client to assess their interest in exploring it further.

The narrative interviewing protocol as a clinical intervention is a 5-step process adapted by the author from Jovchelovitch & Bauer's (2000) narrative inquiry research approach. The Preparation Phase involves obtaining information about and developing an understanding of the client's presenting issues (Akande, 2017b). The practitioner would develop a preliminary plan for the session, including the prompts and open-ended questions. An example of a prompt would be, "You mentioned that you've experienced moments of deep depression since your teenage years. Describe the earliest instance that you can remember in greatest possible detail, along with subsequent experiences." This type of a prompt provides an idea of the possible length of time that might be needed in order to engage in narrative interviewing with the client. Depending on the quality of the prompt, broad and open-ended is best, and the level of comfort of the client, narrative interviewing sessions may go on for hours. Audio or video recording is recommended.

The second step is the Initiation Phase, where the practitioner introduces or explains the narrative interviewing process (Akande, 2017b). This step must not be omitted. It is critical that the client has an understanding that the interviewer hopes to illicit a detailed story and that this story will be uninterrupted. It is also important that permission is asked of the client, both to engage in the process and to be allowed to record. The uninterrupted aspect of listening, on the part of the clinician, takes discipline – as it is likely not a natural stance to take in this type of setting. For that reason, the client must know not to expect it. Past research (Akande, 2017b) highlights the "New to Narrative" phenomenon, where clients expressed great discomfort with the idea of speaking for

long periods of time – with concerns that they were talking too much and that there should be another prompt or question asked. Active listening techniques, such as maintaining eye contact, nodding, or affirming utterances are important. Notetaking is useful and will come in handy in a later phase. Depending on the topic, more than one prompt/question may be needed.

Third is the Narration Phase, where the prompts are presented, the client engages in his or her story, and recording ensues (Akande, 2017b). Any questions to be asked or clarifications needed should be written down by the clinician to be asked later. One of the important characteristics of the storytelling process is the way in which the story is told. People do not always tell stories in a linear fashion and are otherwise event-centered (Mattingly & Lawlor, 2000). Aspects of the story are presented in various ways, that are indicative of conscious and subconscious prioritizations, levels of perceived importance, and chronology. Therefore, a clinician's interruption can not only disrupt the storyteller's train of thought and derail the direction of the conversation, but it can also place undue value on a particular topic that the client did not place there himself. Thus, the act of interrupting on the part of the interviewer can be leading and corrupting.

The Questioning Phase marks the end of the story and the recorder should be turned off. Notes are used for the interviewer to clear up any discrepancies or address any questions (Jovchelovitch & Bauer, 2000). It is best to write notes and ask questions using the client's own words, as a matter of respecting their story and their language, without inadvertently changing it. It is also possible that the act of turning off the recorder and purposefully ending the interview can either consciously or subconsciously place the client at ease and lead to share further components of their stories. It would also be helpful to directly ask the client about what they thought of the experience. This can inform further work in narrative interviewing with this client and others. Formal closing of the session marks finality.

Story-telling is inherent in every culture. Across the world, children are introduced to stories from childhood and can even create their own stories before they have learned to read or write – making different forms of narrative interviewing appropriate interventions for all ages. Various cultures also find great pride in stories, as they carry history, tradition, and garner respect and attention. And importantly, stories enhance the female voice, which tends to be quieter across cultures (Goetz & Nyamu, 2008).

Concepts of health across cultures

Life and death, health, chronic illness, and disability all carry different implications and meanings across cultures. Depending on one's worldview, he or she may perceive a diagnosis to be a punishment from God for their own sins or the sins of their parents, a result of nervousness or being too emotional, or the result of witchcraft or voodoo (James, Navara, Clarke, & Lomotey, 2005; Stone, 2005). Others might believe that it is their duty to care for an ill family member at home and believe it shameful to consider hospitalization. Members of many cultures experience shame related to illness and disability (Yang, Thornicroft, Alvarado, Vega & Link, 2014), and this shame may preclude them from discussing their feelings… or from even engaging in rehabilitation services at all. Using narrative to understand the individual and his or her values can shed light on some of these potential barriers. The mere act of verbalizing one's own story incites reflection and insight that are beneficial to the therapeutic process and problem-solving (Akande, 2017b; Ash & Clayton, 2004). And at times, there can be an awakening experienced or an "Aha moment", where previously unknown underlying stories and experiences are unveiled (Bell, 2002).

Rehabilitation professionals receive cross-cultural training through their degree programs and through continuing education, but all knowledge that is obtained are generalizations that are brought into individual clinical relationships. Social Constructivism is a theoretical framework that acknowledges the unique development of an individual's understanding of the world (Amineh & Asl, 2015). Reality and knowledge are created, or constructed, through human activity. Identical twins born to the same family will still grow into their

own, individual identities – rejecting or accepting the family's prescribed gender roles, religion, child-rearing techniques, and even eating habits as they construct their realities and identities. And this would also apply to beliefs about health and disability. Narrative interviewing not only allows for an opportunity to explore clinical concerns, but it relays respect by expressing cultural humility (Hampton, Guillermo, Tucker, & Nichols, 2017) on the part of the professional. The expert is actually the client, and the rehabilitation professional understands the importance of allowing the client to express their own identity. This can help to break down racial and ethnic barriers caused by assumptions and biases. This can also naturally foster a greater sense of empathy for the client.

Considerations

Narrative approaches to research and service provision are scarce in the field of rehabilitation, but widely used in neighboring fields (Creswell, 2009; Reissman & Speedy, 2007; van derRiet, Dedkhard, & Srithong, 2012). This is an emerging area with great potential for increased engagement of marginalized groups in rehabilitation and human services, along with improved treatment outcomes. Globalization must compel the rehabilitation field to prepare its practitioners to be ready to engage with clients and patients in culturally appropriate and innovative ways.

One of the biggest potential barriers to the Narrative Interviewing approach would be differences in primary language between the practitioner and the client or patient. As stated earlier, having a third-party present, such as an interpreter might hinder the process. Decisions about appropriateness for individual clients must be made on a case by case basis. Similarly, although a person's primary language might be the same as their clinician, language can still act as a barrier because of age or an impaired level of intellectual functioning. Children may not be able to express themselves verbally as well as adults, but much can still be learned from their stories – however short they may be. Using pictures or having children draw pictures to express themselves may be introduced as a modified way of implementing narrative interviewing. Individuals with developmental disabilities, depending on the severity, may or may not be able to fully understand the process, expectations, or be able to consent. In this case as well, decisions about appropriateness must be made on a case by case basis.

Lastly, time-limits are another potential barrier faced by service providers, where billing and large caseloads drive the structure of individual sessions. But like any clinical intervention, no one approach is appropriate for everyone. Professional discretion and input from the client are paramount. It is not to be expected for a clinician to engage in narrative interviewing for several hours with every client. It will become apparent who might benefit from the process and when. In certain instances, it may be appropriate to engage a client in narrative interviewing during the intake process. Opportunities may present themselves at any time throughout the process of providing services, which can also include termination and the cessation of services.

Conclusion

Client story-telling promotes empowerment, celebrates individual culture, and transcends barriers. It is an exploratory technique that is also unifying in nature. In addition to the fact that it is an educational experience for both parties, it is more importantly a therapeutic experience for the client (Hsu & McCormack, 2011). Future endeavors into narrative interviewing, and its implications for practice, research, and teaching in the field of rehabilitation are encouraged.

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