

Cultural vulnerability: A narrative approach to intercultural care

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Qualitative Social Work

12(2) 104–118

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DOI: 10.1177/1473325011420323

qsw.sagepub.com



Abstract

This article uses analysis of focus group discussions with palliative care professionals in the United Kingdom to discuss the value of a stance of cultural vulnerability in intercultural social work. Cultural vulnerability recognizes mutual vulnerabilities in caring relationships. The meanings and potential of cultural vulnerability are explicated through an in-depth case study analysis of a group interview with hospice social workers. Narrative methods are advocated as a resource in supporting practitioners to recognize cultural vulnerability and to work with indeterminacy and difficult emotions. The representation and role of cultural knowledge and racism in social work narratives is given specific attention.

Keywords

Cross-cultural, death, ethnicity, emotions, ethics, racism

Introduction

Using examples of professional narratives generated from a project on older people, ethnicity and palliative care in the United Kingdom (UK), my purpose here is to demonstrate how narrative methods might be used to support holistic care and anti-oppressive practice. In contradistinction to the current social policy discourse on ‘cultural competence’, the article advocates a stance of ‘cultural vulnerability’ based upon recognition of mutual vulnerabilities in caring relationships. It is my contention that narrative methods can enhance the recognition of cultural vulnerability, providing a sensitive and critical attunement to the complexities and ambiguities of intercultural caregiving.

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Despite the longevity and the renewal of interest in the use of narrative approaches with dying people and their carers, far less attention has been given to narratives and meaning-making amongst professionals (however, see McDermott et al., 2006), particularly social workers. Yet, it is widely recognized that caring for dying people can be especially demanding, involving intensities of emotional labour, moral dilemmas and repeated losses (DasGupta, Irvine and Spiegel, 2009; James, 1989). Just as narrative methods have been seen as a valuable tool in understanding meaning-making amongst dying people and those close to them (Stanworth, 2004), it is not difficult to see how professional narratives can also reflect a search for meaning and morality (Frank, 2004a) and a process of identity construction and negotiation (Gunaratnam, 2008).

There are also differences between lay and professional narratives however. What is distinct about professional narratives is that they are a part of wider institutional and social responsibilities. Cicely Saunders, regarded as the founder of modern hospice care, saw these responsibilities as including an obligation to alleviate suffering and social injustices (Melville, 1990). In other words, narratives in the caring professions carry a certain moral status and weight (Frank, 2004a). The content of professional narratives is also influenced by differences in domains of care, disciplinary philosophies and expectations about what it means to be a professional. The term 'canonical narrative' (Bruner, 1990) has been used to describe those accounts that express normative expectations: how things 'should' be. Canonical narratives have relevance in understanding how professional narratives can be deeply personal and context specific, whilst reflecting and being oriented to broader expectations of professional practice.

In what follows, I give critical attention to canonical narratives of intercultural care, focusing upon accounts of the emotional content of intercultural palliative care and using an especially detailed narrative of the micro interrelations between cultural knowledge and fears of racism in social work for a more close-up analysis. The presented accounts should be read with regard to the wider research questions of the project which concerned eliciting narratives relating to four main areas of professional practice: the care of older people and carers from racialized minorities; experiences and perceptions of the needs of these service users; areas of difficulty and challenge in providing culturally responsive care; and care that was seen as being responsive to difference. In this regard, the accounts describe some of the various everyday methods, typifications and practices that can be used as resources by professionals in negotiating and responding to cultural difference in end-of-life contexts and amongst older people. Applying Arthur Frank's (2004b) analysis of the epic poem *Beowulf* to the social work case study narrative, I suggest that some of these resources can include positioning cultural knowledge as a redeeming Grail, whilst racism can operate as the monstrous figure of Grendel, who is to be feared and avoided. The constrained temporal frameworks of care at the end-of-life should be taken into account when considering the extents to which the intensity of such splitting between Grails and Grendels is empirically generalizable to other social work environments.

Cultural vulnerability

There are two key features of cultural vulnerability that I will highlight at this stage.

First, rather than treating culture as a reified entity that people possess and which is the cause of variations in beliefs and behaviours, I approach culture as a sign of complex and promiscuous interrelations between bodies, environments and technologies. In my thinking, culture is not so much a tangible 'thing' that can be tied to particular spaces or populations – it is an event. An event that is contingent and that has topological features: it has the capacity to change and to be changed, to bend and curve with the networks and contexts it finds itself in. And although some of the manifestations of culture may exhibit a certain resilience and substance over time, I understand the significations of culture as being primarily emergent and relational. To think of culture in this way, is also to be alert to our ignorance; to be aware that representations of culture have the capacity to defy rational knowing, so that their effects and outcomes are neither predictable nor easily verified.

Second, and relatedly, I see cultural vulnerability as an ethical stance. This conceptualization of ethics draws upon ethical philosophy (Levinas, 1987) and the belief that the Other always exceeds our capacity to know and to master her. An implication for professional practice is that recognition must always be given to not knowing or to what the poet Keats (1958) has termed 'negative capability': the capacity to tolerate incomplete understanding and mystery. This approach to intercultural care shuns doctrine and formula. As a consequence it is open to the discontinuities and surprises of cultural identifications and performances. Its capacity for emotional resourcefulness and elasticity has a single starting point: that of receptivity to vulnerability and to the unpredictable demands of the Other.

Methods

The development project on older people, ethnicity and palliative care, from which the group interviews in this article are drawn was based in the Black voluntary sector (for further methodological details see Gunaratnam, 2008). The project undertook qualitative exploratory interviews with older people and carers from racialized minorities ($n=33$) and health and social care professionals ($n=56$). Recruitment of professionals was achieved using contacts from the project advisory group and snowball sampling. Effort was made to ensure that different sectors of palliative care provision (i.e. hospice, hospital and community) and different professional disciplines were included in the sample. The main professional groups interviewed were nurses ($n=30$) and social workers ($n=16$). The majority of those interviewed were white British ($n=42$) and female ($n=51$).

The interviews with professionals took the form of focus groups, which involve participants engaging collectively with a topic selected by the researcher (Krueger, 1988). The decision to use focus groups was taken with regard to both

efficiency and because group interactions are relatively naturalistic and offer social contexts of meaning-making, with minimal intervention from the interviewer (Wilkinson, 1999). The interview questions were aimed at inducing narrative, giving priority to the description of events, rather than asking for accounts of opinions or feelings. This is because the latter can be constrained by what is felt to be socially acceptable or desirable, and so can remain somewhat distanced from experience.

Analysing the interviews involved listening to the interview recordings and reading each transcript several times to establish familiarity with the whole interview and to generate descriptive codes to represent the main themes. A process of progressive focusing was implemented in coding, whereby a reading of the transcripts yielded initial topics, which were then grouped into a set of emerging themes. Following this clustering of themes, the range of responses relating to each theme was identified and arranged into sub-themes. Whilst valuable in enabling comparisons between interviews, such coding can result in the fragmentation of narratives (Hollway and Jefferson, 2000; Riessman and Quinney, 2005, Thaden and Robinson, 2010), therefore analysis also included attention to the content of whole narratives or 'narrative units' (Kidd and Parshall, 2000). Throughout the analytic process, attention was given to identifying commonalities and differences between different sites of care and between professional disciplines. The interview transcripts were numbered sequentially according to chronology.

Before presenting the social work case study narrative, it is important to briefly describe the nature of the canonical narratives identified and the specific affective terrain of intercultural care at the end of life.

Canonical narratives and intercultural care as tightrope walking

Three common canonical narratives of intercultural care that emerged in the analysis of the focus group interviews can be summarized as:

- (i) Professionals must have cultural knowledge, either learned or 'natural' (that is, arising from their own cultural/ethnic identities), in order to provide culturally responsive care
- (ii) Professional practice and identity involves action and doing
- (iii) Professionals should facilitate a 'good death', characterized by effective patient-professional partnerships, pain and symptom control, open awareness about dying, harmonious family relationships and care that is responsive to social differences

The rationality and simplicity of these narratives and their commonsense associations is evident (see Gunaratnam, 2008 for further discussion of these components of canonical narratives). Nevertheless, it is important to resist the tendency to understand these narratives as achieving a prescriptive and dominant status simply

through compliance. Although some practitioners used canonical narratives uncritically, there were also areas of differentiation and opposition. For instance, responsive care could be framed through talk about the necessity of discarding preconceived assumptions and through criticism of the literal interpretation and application of cultural knowledge:

... we take the time to think about not making assumptions about families ... and it's very much tapping into what they want. You get the textbook stuff, but actually everybody's interpretation is their own, particularly when it comes to religion and culture. (Nurse, Focus group 1)

I think we need to guard against 'I've read the Ladybird book of religion and therefore I know what Muslims want' ... everyone lives out their faith differently anyway, so in some ways it was better not to read the book at all and say 'How do you want this done for you?' (Social worker, Focus group 3)

I mean you have to be careful that you don't put everything down to culture because the situations are incredibly complex. ... I would actually ask the patient ... because I would prefer to get their version of it, because you may think you know what that culture or that religion generally do, but I still think it's an individual thing. (Nurse, Focus group 11)

There are two interesting features of these examples. First, they point to a cross-disciplinary ambivalence with regard to cultural knowledge: health and social care practitioners can be similarly cautious, perhaps even sceptical, about an easy recourse to culturalist explanations; at the same time, such dissent recentres culture as something that can be elicited and is knowable; it replenishes culture as determinable and care as rationality. Second, the accounts are not strictly speaking narratives, they are opinions that do not recount experienced events.

The cross-group analysis also identified a common and reoccurring metaphor of intercultural care as what can best be described as emotional 'footwork'. In the words of one hospital-based social worker 'We're walking on a bit of tightrope' (Group 7). For a palliative care community nurse intercultural care was described as walking 'a fine line' between knowledge and nescience. He said:

... you don't want to offend, but you don't want to appear ignorant either. So it's a fine line you walk actually and sometimes it's just a gut instinct that you're in there and sometimes you get a window opening of something and you just go with it. ... (Group 6)

Within this symbolism of intercultural care as a precarious walking, fear of cultural insensitivity was not simply related to 'falling', but could also be evoked as an immobilization. A hospice social worker described how not making assumptions about cultural identifications and asking questions 'just frees up the whole

thing, there's less of a sense [of] . . . treading so warily that I'll jam-up completely' (Group 1). Such accounts provide vivid evocations of a 'sensuous knowing' (Taussig, 1993) as the moment-by-moment balancing of knowledge, uncertainty, risk, intuition, and skill. The embodied insecurities of such practice expresses the 'thinking on one's feet' aspects of care (Ixer, 1999) as well as the negotiation between the unforgiving outcomes of 'getting it right' and 'getting it wrong' (Gunaratnam, 1997).

It is important to point out here that despite areas of commonality, accounts of the nature of intercultural caregiving also differed between professional groups. The need for cultural knowledge, in accounts of responsive care, featured more frequently in the interviews with nurses. In the main, it was social workers who also talked about the implications of structural inequalities and histories of racism, reflecting discourses of anti-oppressive practice that are unique to the social work tradition (see Beresford, Adshead and Croft, 2007; Dominelli, 2002; Gil, 1998). For example, in one multi-disciplinary focus group, a social worker talked about how her inability to secure welfare benefits and re-housing for a family (they were recent migrants and not entitled to state benefits and housing) led to her retreat from the family 'because of our embarrassment and feelings of not being able to do anything'. Her colleague remarked 'Yes, . . . there's something about being representative of a, sort of what can feel like a very racist system and how we react as workers around that' (Group 3). As Waddell has recognized, the inevitable social constitution of most forms of suffering produces additional stresses for the social worker as 'an agent for the system on behalf of which (indirectly) he/she is picking up the pieces' (1989: 16).

In thinking about the implications for professional practice of the affective constituency of intercultural care I have found valuable insights in Arthur Frank's (2004b) analysis of the plot of the epic poem *Beowulf*. Through this analysis, Frank proposes that the plot of stories tends to revolve around the presence of the 'G Twins', with one G standing for the destructive power of the monster Grendel, who hunts and kills at night. The other G twin stands for the Holy Grail: a lost object, that if found, is redeeming. Frank avers: 'Grendel represents what we believe can destroy us. The Grail represents some force that can heal us. We fear Grendels; we desire Grails.' (2004b: 214).

Frank's interpretation of the semiotic role of Grendels and Grails, I propose, can be applied to stories of intercultural care. My suggestion is that cultural knowledge can often represent the Grail of caregiving. Knowledge about different cultural traditions and practices can become the idealized lost object that if possessed is believed to unlock mysteries and bridge the perceived distances of difference. Racism, conversely, can signify the spectre of Grendel; the monstrous force that threatens destruction and is defended against with repression and non-naming. The recognition of racism and its impact upon care can thus be simultaneously feared and avoided. A critical challenge for social work in polycultural settings is how organizations and teams might develop new plot lines in intercultural care narratives that move away from the extremes offered by the Grail and Grendel. It is my belief that cultural vulnerability offers such an alternative.

Through the case study narrative, I hope to demonstrate the value of narrative methods in eliciting and engaging with some of the affective challenges of intercultural social work. My argument is that the stories that professionals tell about their caregiving provide unique insight into the psycho-social, embodied and material contexts of care. This is not to suggest that 'narratives of personal experience grant us untrammelled access to a realm of hyper-authenticity' (Atkinson, 1997: 341), but rather that narratives can provide an appreciation of 'the sifting, classification and contouring of experience' (Paley, 2009: 23) which is so vital to reflective practice.

Case study: Elspeth's story

In the following extract from a group interview with three white women hospice social workers, 'Elspeth' (a pseudonym) describes her withdrawal from an Afghani patient following an accusation by the patient's son that she had transgressed cultural norms. This story emerged at the very beginning of the interview, after I had asked an introductory, narrative inducing question: 'So, can you tell me about the care situations that you're involved with in caring for older people from different ethnic and cultural backgrounds?':

There is one situation that comes to mind, possibly because it's something that I felt I didn't do very well. I mean I feel my knowledge is not as good as it could be. I was speaking to a man from Afghanistan... he was very, very anxious... [I] just let him speak and he spoke about the situation in Afghanistan and the terrible things that had happened and why his family had to come over... it was obviously very difficult and he became quite upset and I sort of explored this with him as much as I could and after the session his son came to me, really very angry and said 'You upset my father so much'. He said 'You don't understand our culture. You mustn't talk about these things and you brought up things which should never be brought up', um and I did say to him, 'Well, I didn't bring up, anything, I just spoke to him.' How was I supposed to speak?... But he was very angry, although interestingly, he then asked me if he could come to counselling, feeling that it would be more helpful to him, but his father shouldn't speak. Because his son had done that and I felt so bad about that, I then didn't go back to see his father... I felt, I just backed off... I found that quite scary, because they're traumatic situations that are very different to what I've experienced. I didn't feel that possibly I was qualified to deal with it. (Group 2)

Elspeth's story, edited reluctantly here, is rich in detail, pointing to cultural, gendered and generational differences as well as experiential differences of war and trauma. In mapping these cross-cutting vertices, the plot of the story builds up to reveal the emotional density and practical consequences of the son's accusation. For Elspeth, the accusation is narrated as producing feelings of professional failure and a defensive withdrawal and 'backing off' from the father. From the way in

which the story is told it is possible to gain some insight into both the lure and the effects of cultural knowledge as a Grail; a redeeming resource in intercultural care.

Elspeth's lack of knowledge of Afghani history and cultural prescriptions is a recurrent theme in her story, adding potency to the son's accusation of cultural insensitivity. Elspeth's account of her defensive response to the son: 'Well, I didn't bring up anything. I just spoke to him' followed by the question: 'How was I supposed to speak?' is especially interesting. 'How was I supposed to speak?' has various meanings. It is an expression of helplessness and a lack of alternative possibilities. It suggests exasperation, whilst also functioning as a rhetorical plea for guidance. Perhaps, the most potent signification is the tension that the question points to between differences in cultural values with regard to emotionality. This tension is further entangled with gender and inter-generational relationships. An implication from this thematic reading of Elspeth's question is that greater knowledge of Afghani culture and history would have rendered Elspeth more 'qualified' to provide culturally sensitive care for the father.

There are also areas of ambivalence and contradiction in the story. At times, Elspeth seems to make attempts to examine critically and carefully the source of the son's anger. She narrates that whilst the son mobilizes cultural difference to question her use of counselling with his father, he sees the potential value of counselling for himself. However, this fleeting recognition of inter-generational nuances gets lost in Elspeth's feelings of incompetence because of a lack of cultural knowledge and shared experience ('I didn't feel that possibly I was qualified to deal with it'). And, although Elspeth says that she tried to advocate for the autonomy of the father's decision to talk about his experiences ('It's your father's choice'), she appears uncertain of the ethical basis of her judgement. The recognition of accretions of cultural difference and inter-personal relationships in the story implies that Elspeth can see something of the complications that underlie her encounter with the son but that she is unable to respond to them fully. The result is that in her telling of the story, both Elspeth and the son are caught in a vortex of heightened emotions and the father is left alone with his traumatic experiences.

Racism: The monster in the room

In addition to the portrayal of the effects of a lack of cultural knowledge in the narrative there is a further dimension to this account: the effects of white guilt about histories of racism. It is significant that Elspeth was only able to speak about the impact of racism in her story later on in the interview and after her colleagues had joined in the discussion, using further practice-based examples and demonstrating empathetic understanding of Elspeth's story. The following edited extract, records what happened in the discussion immediately after Elspeth's account:

Monica: I think that's a very good point, isn't it?... Elderly people or young people who come from different cultures and who have been traumatized... they need to actually talk about these experiences... but... is it actually helpful for them or not to

talk about it? But then, in a way, it's their choice, isn't it? Like... your client, he wanted to talk, so actually there's a family issue, then, isn't there? A cultural and a family issue, which then becomes complicated...but...we have that with white families... I do think it's difficult sometimes in palliative care, because different cultures have very different attitudes, cultural attitudes, towards the process of how you care for a dying person... because we've had people from several cultures who've been very clear that 'We don't talk about it' and fine, you have to respect that, but as a professional, working in palliative care, I think that can sometimes be difficult... We've had that quite a bit, haven't we?

Sarah: Yes... I think it's important to try and... to make sure you don't get scared off giving people choices, but I think it can sometimes make you scared to offer those choices, is that going to be imposing?...

Elspeth: I think we've all been trained, so it's drummed into us, that we are conditioned to ask questions and that although we're very curious and we want to know about someone's culture and how it impacts on them... there's still the sense that we are white and British and that can... take away our voice, which is quite interesting, because we think of ourselves as powerful people and we're holding guilt that we have abused people in the past, I mean racism... When you are sensitive to other cultures, it can actually have the opposite effect of making you so sensitive that you have no voice anymore.

The exchange between the women articulates some of the frequently hidden contortions of guilt and shame about racism that can accompany this form of intercultural social work (where the practitioner is from a dominant cultural group). At first, the social workers keep the topic of racism at a distance. Monica and Sarah demonstrate a broad identification with Elspeth's story, but they pick up on the themes of individual choice, inter-generational and family relations, and professional anxiety. Although the themes are obtuse to what Elspeth has in mind, the identification of commonalities of experience appears to provide a supportive space and opening for Elspeth. When she next speaks, she is able to name racism and identify some of the chaotic and negative feelings that can accompany awareness of racial injustices. Elspeth's talk of resentment at the taking away of professional voice demonstrates how these feelings can be expelled onto service users and carers, who become fantasized objects of fear, threat and unexpressed anger (see Gunaratnam and Lewis, 2001).

As Frank has argued 'naming humanizes fear' (2004b: 215). The idea here is that naming and recognition can disempower the imagined destructive forces of Grendel, by placing fear and anxiety in the realm of concrete relationships and situations. It is through this capacity to name some of the more threatening features of intercultural care that it is possible to see a further value in the ethical potential of professional narratives. We can perhaps see the beginnings of this potentiality in the closing lines from Elspeth in the second extract. In this excerpt,

Elspeth identifies the perversity of a vicious cycle of emotions in which sensitivity to cultural difference can be the very cause of more constrained, but also sub-optimal care. The irony of the situation is that it is precisely the desire for an idealized cultural knowledge that is narrated as generating some of the distances between the father and Elspeth, leaving both estranged.

Despite an inability to fully own responsibility for the breakdown of care in this situation, Elspeth's narrative shows her colleagues something of the value of naming and humanizing fear of racism. It also allows Elspeth to express her vulnerability to the moral demands and the 'gifts' of difference that disrupt routine caregiving and provoke deep thinking about values and their imbrications in local and wider contexts (Gunaratnam, 2009). Sayantani DasGupta, a physician in the Program in Narrative Medicine at Columbia University, has named this non-volitional susceptibility to the effects of others as 'narrative humility'. For DasGupta (2008: 980) narrative humility is antithetical to approaches to cultural competence that can become 'a sort of cultural mastery of marginalized communities'. In contrast, narrative humility – in similar ways to cultural vulnerability – enables a practitioner 'to place herself in a position of receptivity, where she does not merely act upon others, but is in turn acted upon' (p. 981).

Seeing beyond the category

It is important to reiterate that vulnerability to Others can be especially difficult in the time-scarce/emotion-rich environments of care at the end of life, where physical and existential suffering collide and where the time to build up relationships and understanding of patients can be limited. At the same time as being sensitive to processes of racialization and to the possible interrelations between cultural identifications and biopsychosocial experiences of illness and dying, practitioners must also learn to remain open to the singularity of pain and suffering in the lives of those they care for.

From my interviews with older people from marginalized ethnic groups, I have found that this is often a theme in their stories: their pain and suffering can become obscured by the attention that is given to *what* they are rather than also to *who* and *how* they are. For example, Jamaican-born Martha foregrounded relationships between her gender, marital status and assessments of her mental health – that cannot be separated from the racialized over-diagnosis and medicating of mental illness in Black Caribbean populations (see Department of Health, 2005) – as leading to the misdiagnosis of her cancer over a period of 18 months at her local hospital. She told me:

...eighteen months I have been going to that place (the hospital) and I was really treated badly ... it's just because they're not looking at the right place. They're not listening to me, 'Oh, its depression' and give me anti-depression and I say 'I don't want anti-depression tablets, I am not depressed and because I'm divorced with 7 children, I'm supposed to be depressed, you know and nobody takes any notice'.

'They're not looking at the right place' is a dictum that has varied registers. In the diagnosis of disease, there is indeed sometimes a 'place' to look, where the causes of pain and symptoms can be identified and therefore 'known'. In psychosocial care, there is more obvious indeterminacy, but there remains an expectation that practitioners will be able to 'see' the varied sources and cumulative consequences of the distresses they encounter. In the case of Elspeth's narrative, this would in many respects entail a double-think: acknowledging the central position that Elspeth can give to cultural difference that keeps her – in Martha's words – from 'looking at the right place' whilst at the same time recognizing that the security of such a locatable 'place' can itself be an illusion.

It is also important to point out that the demands of working between levels of knowing and not knowing are not restricted to intercultural care. In the following interview excerpt an Indian-Hindu nurse describes her care of an older Indian-Hindu patient. The patient had been a qualified teacher in India, but had not been able to get a teaching job in the UK and had worked as a bus driver and in factories until his retirement. The nurse said:

I think it had an impact on how he dealt with his condition, because unfortunately his diagnosis had been quite delayed... he said, 'I know I'm educated and I know I'm completely in the wrong box. I think they haven't treated me properly because I am who I am, because saying I was only good enough for bus driving, not for teaching and for the same reason they didn't think I was important enough to be diagnosed early enough to be treated in the right way'. And I found that very hard. That was really difficult, that was hard for me to take. I mean what can you say?... What can I actually say to him that's actually going to make a difference to him and I found that really difficult. (Group 6)

This narrative is significant because even with the presence of ethno-cultural affinities, it shows something of the redundancy of cultural knowledge in the face of the pain of felt racism. For the nurse, there are simultaneous feelings of professional responsibility and inadequacy, a questioning of care as an active doing and 'fixing', and a singularity of the patient's experience that is demanding some level of response that she feels unable to provide ('what can I actually say to him that is actually going to make a difference to him?'). In this instance however, the responsibility for the inadequacy of an appropriate response is recognized and held rather than being outsourced to the role of cultural difference.

Of course, we cannot discount the ways in which configurations of culture might impact upon caring relationships. In its reified versions culture can be deployed strategically to achieve certain goals (such as protecting a son from the pain of his father's distress), it can also be questioned and re-imagined. In the care situation that Elspeth describes it is possible that cultural prescriptions that inhibit the expression of emotions amongst older Afghani men were in play in her relationship with the father. It is also possible that at this time of his life, and with a young

woman from a different cultural background, the father was more able to question these prescriptions. In such circumstances, attention to narrative accounts can help practitioners to explore varying possibilities, such as how a lack of cultural knowledge and the lack of shared experiences (and therefore also shared judgements) might facilitate responsive and anti-oppressive care. Unfortunately, this is a possibility that at the time of narrating her story, Elspeth was not able to recognize.

These negative aspects of Elspeth's narratives should be read alongside its less dominant features and dynamics. In telling her story and having it listened to, Elspeth was able to engage with some of the relationships between wider professional values, canonical narratives and care practices. Her story represents both the ethical potential of a freedom from canonical narratives and the emotional pain of being on the outside of such narratives. From the vantage point of an outsider, Elspeth could identify some of the consequences that a fear of racism can entail in intercultural social work. A further engagement with Elspeth's story, whether at the level of supervision or critical incident analysis, could support the development of ways of thinking and working that are less defensive and damaging and which allow practitioners to express and share anger at the injustices of racism. In different circumstances, Elspeth might have been enabled to negotiate a more productive path through her relationship with the father and son. Such a relationship could recognize their trauma and loss as culturally and historically situated, but also singular and biographical.

Narratives as care

In this discussion, I have wanted to demonstrate how narrative approaches to intercultural care can recognize and work with, rather than suppress vulnerability and levels of ambiguity in caring relationships. This is an approach to narrative, where the methodological, the ethical and the therapeutic are mutually implicated (see also Bochner, 2001).

Work with professional narratives is already being used in innovative ways as a part professional education and training in health and social care (see Froggett, 2002 for social work examples). For instance, within the Narrative Medicine Program at Columbia University, practitioners are introduced to a variety of narrative methods that include literary criticism and writing about and reflecting upon their own care experiences. An account of a workshop participant's writing on the Narrative Medicine Program described by DasGupta, Irvine and Spiegel (2009) is pertinent here. The participant, a senior clinician and teacher, wrote about an encounter with an oncology patient that had troubled her for over 30 years. The doctor described how she had been asked to remain with the patient while the patient regained consciousness following surgery; the surgery had found the patient's cancer to be too wide-spread for surgical treatment. When the patient

became sentient, she asked the doctor ‘Am I dying?’ As DasGupta, Irvine and Spiegel explain:

The written account did not include the answer the physician gave. What was implicit was her sense of failure in that moment, as she simply had no idea what to say. Even to this day, now a well-established teacher, the physician is still struggling with this story. Is there, after all, any kind of technical or skill training, any pre-packaged language to prepare one for such a moment? The contention of Narrative Medicine is that in developing and deepening strategies for attending, representing and affiliating with patients and with colleagues, caregivers gain confidence in their ability to face their own fears and dread of just such an inassimilable moment . . . that is, they will cultivate the combination of *humility* (DasGupta, 2008) and confidence called for in such a moment – to be present in oneself. (p. 45, emphasis in original)

‘To be present in oneself’ implies having to receive and contain the pain of others in person, without the intervening props of activity, procedure or pre-packaged knowledge. Similarly, Waddell (1989) has identified the importance in social work of receptive passivity, which she terms ‘serving’. In the emotionally tumultuous worlds of social work, Waddell contends that serving is displaced routinely by ‘servicing’. In servicing, the frenetic activity of ‘*doing* things for people’ (p. 20 my emphasis) is theorized as providing a temporary distraction and relief from the emotional demands and intensities of working with pain and suffering.

The notions of ‘humility’ and ‘serving’ are pertinent to this discussion because they recognize the value of an unknowing receptivity in professional practice and because of their status as interventions that interrupt the aspiration to formulaic approaches to caring. Narrative methods, as I have hoped to demonstrate, can have similar benefits. My argument has been that if professional narratives are understood as being caught up in vital, indeterminate processes and relationships, rather than being transparent descriptions, routine practices or mere anecdotes, then practitioners can be better supported to ‘serve’ rather than to ‘service’ the people that they care for. What is experienced as being overwhelming and anxiety provoking, often accompanied by feelings of fear, bewilderment, ambivalence, anger – and in the case of recognizing racism, shame – can begin to be acknowledged and attended to. As the case study example shows the Grail of knowledge of a patient’s culture and the Grendel of racism are so emotionally freighted that they can hinder serving and can obscure the appreciation of the singularity of an individual’s experience within broader social histories and conditions.

Ultimately, the value of professional narratives is that they are experience-near and context-saturated. When brought back to their origins in relationships with vulnerable people, professional narratives of intercultural care are much more than encoded descriptions of what has already happened. Practised with humility and a stance of cultural vulnerability, professional narratives can commune with and create possibilities for what might be.

Acknowledgements

With thanks to the research participants and to the insightful and provocative comments of the editor and two anonymous referees.

Funding

This research was funded by the Department of Health grant number S645063.

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