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Article abstract

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Narrative Care and Engagement in Social and Health Care: Enhancing Identity with a Small Story Approach

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Narrative care, an approach developed from the larger concept of narrative gerontology, considers the importance of stories as a source of identity. A type of person-centered care, narrative care in care settings encourages care workers to elicit stories to gain a more wholistic understanding of the person. Drawing on personal experience in the field, I argue that although "big" story approaches (e.g., grand life narratives) have typically been used in social and healthcare settings, "small" story approaches (e.g., snippets or moments) are more practical for care workers. The expansion of the concept of narrative care to include "narrative engagement" will be explored, which if applied in meaningful ways can promote citizenship, shift power dynamics, generate empowerment, and create systemic change in social and health care settings. Finally, newly developed train-the-trainer narrative care training will be discussed, which is designed to meet the needs of diverse social/health care workers, with a focus on meaningful methods of adopting narrative care and engagement in practice.

Keywords:
narrative care, narrative engagement, narrative identity, social work, healthcare, citizenship

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INTRODUCTION

There is increasing interest in and appreciation for the benefits of narrative care approaches in both health and social care fields. Arising from the field of narrative gerontology, narrative care is often considered an approach adopted for use with older adults in care settings such as long-term care, hospice, or hospitals. However, there is great potential in expanding the application of narrative care beyond the realms of gerontology and aging. Working as a frontline social worker, I quickly recognized two gaps in frontline workers' ability to meaningfully and sustainably practice narrative care: 1. Time constraints and limited resources required a small stories approach (rather than drawing only on big story methods) to narrative care so that narrative interactions and engagement can take place during day-to-day tasks, and 2. Comprehensive training materials needed to be developed to help health/social care workers effectively implement narrative care training or initiatives within their workplaces in applicable and meaningful ways. In this paper, I will explore the theoretical concepts of narrative care, including a focus on a small story approach. I will discuss the expansion of the concept of narrative care to include "narrative engagement," which if applied in *meaningful* ways can promote citizenship, shift power dynamics, generate empowerment, and create systemic change in social and health care settings. Finally, I will share and discuss a newly developed train-the-trainer narrative care training, which adopts a cascading model of delivery. The training is designed to meet the needs of diverse social/health care workers, with a focus on meaningful methods of adopting narrative care and engagement in practice.

NARRATIVE GERONTOLOGY AND NARRATIVE CARE

Narrative gerontology is a multidisciplinary approach to studies in aging which arose in the 1990s and is often credited to scholars James Birren, Hans Schroots, Gary Kenyon and Jan-Eric Ruth (de Medeiros, 2016). Ruth (1994) coined the term, and through its development (Ruth & Kenyon, 1996; Kenyon & Randall, 1999), narrative gerontology was established as a "lens through which to view the aging process" (Kenyon & Randall, 1999, p. 1) rather than a specific theory or method. Narrative can be defined in diverse ways, though de Medeiros (2016) draws on key narrative theorists and definitions to create a succinct, yet comprehensive and clear definition, which will serve as the definition of narrative for this article. de Medeiros conceptualizes narrative as "a telling some aspect of

self through ordered symbols, whereby symbols can include language, images, movement, and other forms of expression" (de Medeiros, 2016, p.14). Narrative gerontology posits that humans are storied beings, fundamentally storytellers and listeners who interpret and act on the basis of stories at all levels of being (Kenyon & Randall, 1999). In this way, individuals are seen as not only having stories to share, but as being these stories (Kenyon & Randall, 1999). At its core, narrative gerontology recognizes and respects that older adults are more than a set of medical symptoms, cognitive capacities, or social roles. While there are physiological, psychological, and social dimensions to who we are, there is another dimension that is typically overlooked: the biographical, or "storied" dimension (Kenyon, Birren, & Schroots, 1991; Kenyon & Randall, 1999). In few fields is this more obvious than gerontology, for what often impresses us about older adults is the stories they have, and need, to tell. Further, narrative gerontology approaches the study of aging with curiosity to understand the implications of "life as story" and how the stories we tell of ourselves, and others tell of us, shape our identity (Kenyon & Randall, 1997).

Exploring the stories of who we are can be essential to our self-esteem, or sense of personal meaning, our spiritual well-being, and even our physical health (Kenyon & Randall, 1997). Ultimately, our stories may be our most precious possession and understanding them our most pressing concern. As we view life from a narrative perspective, we see that sharing our stories with one another is far from an idle activity. It is how we evolve our full humanness. In addition to discovering the incredible complexity of the stories each of us is, we also come to appreciate the transformative role we can play in the lives of others, by listening to their stories with openness and wonder, curiosity and compassion, humility, and respect.

Narrative care. Narrative care emerged from the field of narrative gerontology and involvesdeliberately listening to the story of the person being cared for and honouring that story. Narrative care sees "the story," in all of its complexity and depth, as key to understanding "the person" on numerous levels: emotionally, spiritually, behaviourally, and medically (Kenyon & Randall, 1997).

Narrative care is a distinct approach to person-centred care, an approach to care, typically with older adults or those in health care settings, that places the individual at the centre of decision-making (Kitwood, 1997; Mitchell & Angelli, 2015). It is a humanistic approach, grounded in mutual respect, equality, and shared decision-making (Mitchell & Angelli, 2015). Kitwood (1997) conceptualized and applied person-centred care in the field of dementia care and is considered a pioneer in LTC generally. As a method of person-centred care, narrative care draws on

narrative and narrative identity in its application. It is grounded in a core idea that "personhood," "selfhood," and "identity" cannot be separated from the intricate web of stories we, and others, have told about ourselves across the years, and that these stories define what our life has been. As such, narrative identity can be understood as "a person's internalized and evolving life story, integrating the reconstructed past and imagined future to provide life with some degree of unity and purpose" (McAdams & McLean, 2013, p.233). Consequently, narrative care posits that individuals' lifestories and thus identities, can be (and are) "re-storied" through narrative interactions, experiences, and interpretations.

Narrative care is also mindful of the web of larger stories within which our personal stories are rooted, and by which many of their themes and genres are clearly informed (for example, family stories, community stories, corporate stories, stories of our culture, gender, creed, and race, etc.). In its most basic form, narrative care simply asks us to see the person in front of us as an individual whose identity and personhood cannot be separated from the intricate web of stories that define their life. As Baldwin (2015) states:

> Narrative care is concerned with how people structure their stories and thus bring meaning and significance to their lives. It is also concerned with how people construct their identities in the face of life's vicissitudes, and how they characterize, and thus shape, their relationships with others and the world. Narrative care is thus personal, experiential, concrete, and communicative. (p. 188)

When we begin to see people as these stories, it helps us, as those working with and caring for individuals, to appreciate the "back story" to a person's decisions, attitudes, and behaviours. It also shifts our focus and the importance we place on truly engaging people about their stories when we understand that they do not only have stories to share, but without these stories they would not exist. It is also important to note that there are different conceptualizations of narrative care (e.g. how to elicit and promote narrative identity in those you interact with), categorized as either big or small story approaches. Following is an overview of each.

Big stories

Traditionally, narrative care has been conceptualized from a "big stories" lens, which focuses predominantly on linear, structured life stories

(McAdams, 2001, Berendonk & Caine, 2017), where individuals chronologically share events that have contributed to their overall lives. Big stories often focus on the "larger" stories (e.g. key defining moments), which make up the "whole" of a person's lifestory and are authored by this person alone. A big story approach generally follows the typical story arc, meaning they have a beginning, middle, and an end, and can be reflected in the form of autobiographies, memoires, sharing circles, journaling, an so on. (Berendonk et al., 2017). There are several different strategies, activities, and/or exercises to elicit and engage "big stories" from individuals with the goal of promoting and strengthening personal identity, health, and well-being (Baldwin, 2015).

There is great potential in a big stories approach to narrative care. The act of revisiting life events provides purpose, inspiration, cohesion, and a critical understanding of self. I was fortunate to work in an organization where beautiful big story narrative care work was adopted. Some of these initiatives were taking place at an organizational level, though the majority were being carried out by the recreation department with residents. Some examples of big story approaches included: auto or biographical work being completed during the transition to living in the home to provide "background stories" on the individuals to help improve care (see Clarke, 2000; Thompson, 2011), reminiscent (the recall of past experiences) workshops (see MacLeod et al., 2021; Randall, 1986; Cooney et al., 2014), guided autobiographical work (see Doraisamy et al., 2022; Birren, 2006; Birren & Cochran, 200), object prompting narrative circles (where an object is shared/shown such as an old telephone, a kitchen utensil, a tool, etc. and each person shares any memories the object elicits for them) (see, Buse & Twigg, 2016; Phenice & Griforre, 2013;), music as a memory prompt (see Sedikides et al., 2022), and others (Kindell et al., 2014). While these initiatives were beneficial, and certainly important, there were some limitations in who could participate in or facilitate them.

One limitation of a big story approach is that it often requires the individuals participating to be able to draw on specific, temporal, and structured events of the past (McAdams, 2001) and organize these in chronologically accurate ways. Consequently, big story approaches privilege those with the capacity to draw on long-term memory and language-use, as well as other able-bodied aspects of existence, including hearing, writing, and self-awareness. Drawing upon a big stories approach is somewhat more challenging when engaging and working with differently abled individuals, such as those living with dementia, those living with experiences of trauma, as well as those living with any physical differences, which might impact their ability to engage in such activities.

Another challenge of a big story approach to narrative care is that it can be a time-consuming activity, and often falls outside the scope of practice or ability for many social and health care workers, especially in recent years with increased managerialism within these sectors. Managerialism focuses on making organizations "more effective and efficient" through improved business practices, as opposed to knowledge or skills regarding social or health services (Mullaly & Dupré, 2018, p. 51). This often results in task-focused and efficiency-driven environments where value is placed on high efficiency, yet low expenditure, creating program and resource retrenchment (Spencer, Massing & Gough, 2017; Mullaly & Dupré, 2018; Haight et al., 2016). Consequently, it becomes increasingly difficult for social and health care workers to engage in any additional engagement or activities, as they are already over-burdened by their daily tasks and requirements (Coventry et al. 2015; Schweitzer & Krassa, 2010). Given these restrictions, it is important that social and health care workers can conceptualize narrative care in a way that allows them to authentically integrate the approach into their work in meaningful, rather than tokenistic ways.

The big stories conceptualization of narrative care is what I initially brought with me into practice as a new social worker in LTC and health care settings. As I began working with various individuals, I found myself drawn to, and drawing on, various aspects of this approach of narrative care, though quickly realized the limitations of adopting this approach within the parameters of my work settings. However, I knew and had experienced the value of narrative care in my work with individuals and did not want to fully let go of it in my practice. As such, I adapted the core and foundational principles of narrative care into smaller, more practical ways of carrying them out in practice. Initially unknowingly, I was adopting and implementing a small story approach to narrative care.

Small stories

Bamberg and Georgakopoulou (2008) propose small stories as an "antidote to canonical narrative studies" (p.377). That is, narrative, stories, and identity have traditionally been understood and researched using "big story" approaches to narrative (e.g. the biographical and individualist approaches described above), though there is room to expand this to understand narrative and stories in the smaller, everyday situations, and how people use these interactions (and stories) to create and re-create an understanding of self, and thus identity (Bamberg & Georgakopoulou, 2008). According to the authors, they coined the term "small stories both for literal (these tend to be brief stories) and metaphorical

reasons (i.e., in the spirit of a late modern focus on the micro-, fleeting aspects of lived experience)" (Bamberg and Georgakopoulou, 2008, p. 379). Small stories encompass a number of traditionally under-represented aspects of narrative, including future or hypothetical events, omissions or refusals to share, and sharing about on-going or known events (Georgakopoulou, 2007). Compared to "grand narratives"/big stories (Lyotard, 1984), which are typically coherent, focus on the past, and have a beginning, middle, and end, small stories can be about seemingly "nothing" (Bamberg & Georgakopoulou, 2008). One might share a very recent, incomplete story of an evolving or unfolding event, or perhaps tell of an event that "may or may not have actually happened" (Bamberg & Georgakopoulou, 2008, p. 381). Small stories may be brief, fleeting, incomplete, or elaborative stories through on-going conversations/dynamics.

Georgakopoulou (2007) describes these small stories and everyday narrative interactions as key to personal identity and subjectivity as they are intimately connected to social practices and "talk-in-interaction" (p. ix). Through a small story approach to narrative, Bamberg and Georgakopoulou (2008) shift the narrative conversation to include a focus on the social functions that narratives play in people's everyday lives. A small story narrative approach is interested in the action-oriented functions that stories serve in constructing and/or co-constructing identity in social interactions (Bamberg and Georgakopoulou, 2008). Through multiple "small story" interactions and continuous engagement with others, individuals construct and understand their identity and sense of self (Bamberg and Georgakopoulou, 2008). It is almost as if, through each "small" social and narrative interaction with others we are practicing our "selves." We then receive narrative feedback and experiences, which either reinforce or challenge our existing understandings of identity and selves. We then interpret and internalize these interactions and they add to (or perhaps take away) from our identity. Ultimately, even the "smallest" of interactions contribute to our emerging and evolving notions of self and identity. This is where, and how, big and small story understandings of narrative diverge. Small story approaches to narrative are interested in how engagement with others, using small stories, individuals "construct a sense of who they are, while big story research analyzes the stories as representations of world and identities" (Bamberg and Georgakopoulou, 2008, p. 382).

The concept of small stories is not reserved to narrative care alone, though there is potential and opportunity in adopting a small story approach to narrative care. With a small stories approach to narrative care there is an understanding that the stories we create and tell of ourselves over the years, which define who we are, are not only made up of large, climactic events. Rather, the

small, everyday interactions and events between individuals are recognized as equally as important to the generation of our life stories, and consequently our identities. Bamberg (2006) refers to this as valuing the narratives that appear in day-to-day, routine, conversations. A small story understanding of narrative care opens endless possibilities of engaging individuals to learn about past stories, and supports the co-creation of new ones, even in situations where they might not be able to recall or recount the typical "big stories." Small stories are thus rooted in the present, here-and-now social situations, and are co-constructed through conversation and interaction. Consequently, small stories do not always possess the characteristics typically associated with big stories such as plot, theme or narrative arc. However, given that the focus of small stories is the narrative interaction and the construction of self and identity, these seemingly incomplete or mundane stories do not need to adhere to the "big story" conceptualization of what a story is to be effective or meaningful.

A small stories approach based on relational interaction and conversation broadens the potential and scope of narrative care in social and health care, as narrative care can be intentionally carried out through "ordinary" daily activities and tasks. As explored above, big story approaches to narrative often require the time and resources to elicit stories and support identity. This is not always possible for frontline workers and a small story approach to narrative care allows greater opportunity to engage with those we work with in meaningfully narrative ways, which serve to support individuals' senses of self and identities. A small stories approach requires the ability to skillfully read and collect such small stories over different times and places so that they may be knitted into patterns that can be used to support the identity of the person and demonstrate the respect and value these stories, and thus the person's identity, deserves (Berendonk et al., 2017). In this way, small stories make room for thematic understanding of a person's lifestory, rather than a linear understanding necessary with a big stories approach. Themes are repetitions within, and across, stories and are components of a story that tend to frequently reappear, in one form or another.

The benefit of a small stories approach to narrative care is that the individual does not need to be able to draw on memory or linear facts from the past in order for the narrative care process to be meaningful or useful. Themes allow the health or social care worker to engage with the individuals on a narrative level, despite any changes in cognitive or physical ability. Further, a small stories approach to narrative care allows the worker to carve out spaces for narrative care

amidst any possible workplace constraints. To do this effectively the worker must be, and remain, curious about those they work with.

Curiosity and small stories

An effective small stories approach to narrative care requires curiosity; an inquisitive interest in others; a desire to know (Renner, 2006; Phillips 2014). To do this, the social or health care worker must be open to developing rapport and a professional relationship with the people they are working with. While social and health care workers often have baseline knowledge about those they are working with, such as their histories, preferences, and interests, a small story approach to narrative care suggests this alone is not enough. To preserve and respect the person's identity, workers must inquire and ask about the "why" behind certain decisions, preferences, rituals, and more. Curiosity and seeking the "why" broadens workers scope of understanding of the person and the narratives that have defined and shaped them into who they are presently. Narrative curiosity helps the worker generate small stories and pull together themes, which they can knit into patterns. These can then be used to support the identity of the individual.

While I see merit in the inquisitive "why," in my experience I have found taking the narrative curiosity a step further by strategically asking questions, and engaging with the individual to build on particular themes helps to facilitate an important secondary step to the curiosity: acting. In this way, I suggest that a small stories approach requires workers to not only ask (that is, narratively engage with the whole person as a storied being), but then to act, drawing on the new information and themes to facilitate new stories and experiences based on the identity of the person, grounded in the co-created relationship and rapport established between one another. Drawing on a small story approach to my narrative care practice, and reflecting on the curiosity approach of "ask and then act," I started to question the accuracy or appropriateness of solely using the language or term "narrative care" to describe the approach I was proposing myself and others adopt in their efforts to maintain and honour individuals' narrative identities. I slowly transitioned into pairing the terms "narrative care and engagement," which felt more authentic and descriptive of the small stories narrative approach I promoted.

NARRATIVE ENGAGEMENT

I envision a collaboration or partnership, as narrative engagement comes alongside narrative care, in various social and health care settings. It is important to highlight that in adopting the term "narrative engagement," I do not intend to minimize or discredit the valuable, meaningful, and necessary work encompassed in the concept of "narrative care." Shifting the language from narrative "care" alone, to include narrative "engagement," was important for a number of reasons, which I will explore below. However, it was primarily important simply because language matters! If I ask, "What comes to mind when I use the words narrative care?" Perhaps, like me, you think of healthcare, older adults, fragility, employment, dependency, power imbalance, and healthcare? Now, if I ask the same of the words "narrative engagement," what comes to mind? Possibly, collaboration, connection, discussions, reciprocity? Including "engagement" in our conceptualizations of narrative work in health/social settings broadens our understanding of the work.

Using the term "narrative engagement" is important for narrative in health care, though particularly in social care, and has been important in my own work. First, it depicts a natural, organic, and collaborative way of "being" with individuals exactly where they, and we, are in the present moment. Secondly, it allows for flexibility, personalization, and authenticity in the conceptualization of a small stories approach to narrative care, which better suits diverse workplace settings (and not just health or long-term care where the term is typically adopted). Third, using the term "narrative engagement" creates a distance between the worker's job tasks (e.g. "care") and the act of narratively engaging with the individual (in an effort to support identity). Fourth, the language shift to include "engagement" reduces power imbalances between the "narrative care worker" and "recipient" to a more reciprocal and balanced relationship based on mutual respect and rapport. Finally, "narrative engagement" broadens the conceptualization and understanding of the expectations of the approach, moving beyond simply "asking" towards "acting" and embodying the approach in all interactions.

The goal of narrative engagement then is to carve out an understanding of, and space within existing workplace parameters, to be able to do this in meaningful ways, which moves beyond the somewhat tokenistic, albeit well-intentioned, applications of narrative care. This is no fault of those in health and social care settings. We must remember the system/structure is not organized for engagement in relational and (dare I say) human ways. However, embarking on a small story approach to narrative engagement in our work creates space for

authentic engagement and the co-creation of new stories, experiences, and the strengthening of self-identity. Adopting a small stories narrative engagement approach in these ways is mutually beneficial to both the worker and those they are working with. It enriches the individual's identity, provides purpose and empowerment, facilitates opportunities to co-create new stories and experiences, and strengthens rapport and relationship. This, we know, makes working with individuals easier and more enjoyable, which in turn contributes to positive workplace culture, staff satisfaction, reduced use of sick days, reduced burnout, and more (Graham et al., 2011; Ingersoll et al., 2002; Tourangeau & Cranley, 2006). Further, engaging with individuals in these ways, particularly individuals who are not often afforded much power, voice, or purpose, can promote personhood and citizenship.

Promoting personhood and social justice through narrative engagement

As a social worker, a unique and defining feature of the profession is that social work acknowledges the environmental and structural (that is, systemic) factors contributing to individual experiences and identity. Thus, social work is particularly concerned with experiences of oppression and marginalization and how we might change systemic and environmental barriers to create a more just and equitable society. Oppression can be defined as "the domination of subordinate groups in society by a powerful (politically, economically, socially, and culturally) group (Mullaly & West, 2018, p. 6), whereas marginalization is being excluded from society (Dominelli & Ioakimidis, 2015), or rather, living in the margins. As a social worker, I pay extra attention to language-use, power dynamics, and social justice efforts in all the work I do. In this way, I recognized how many individuals accessing social and health care services experience a decreased sense of power, limited voice, and are frequently experiencing oppression and marginalization. Further, there is significant literature on how those in LTC and healthcare settings, those with new medical/mental health diagnosis, and those involved with state mandated social services experience a loss of identity (Quick & Scott, 2019; Riedl, Mantovan, & Them, 2013; Gillies & Johnston, 2013; Wisdom et al. 2008).

The beauty of adopting and enacting narrative engagement in these sectors is that it shifts the power dynamic and aims to create a more balanced professional relationship based on mutual respect and interest. In doing so, individuals have more of a voice and are provided with space and opportunity to become active participants in their stories and experiences. This results in narrative agency and identity and leads to empowerment. Empowerment is defined as "a

process through which oppressed people lessen their alienation and sense of powerlessness and gain greater control over all aspects of their lives and their social environment" (Mullaly & West, 2018, p. 309). Through the work of empowerment, individuals become empowered, that is, understanding they have power and control over their lives, stories, and identity.

A narrative engagement approach in social and health care also broadens the understanding of what it means to be a person in these settings, and the rights which are intrinsically connected to this status. As I explored above, Kitwood (1997) transformed care approaches in LTC, conceptualizing personhood. However, this notion of being a person did not expand upon, or include, language for discussing, understanding, or changing people's contexts in terms of power (Baldwin & Greason, 2016; Bartlett & O'Connor, 2007). While narrative engagement promotes personhood, it goes a step further in recognizing power dynamics, aiming to promote citizenship. Citizenship can be defined and contextualized in many ways, depending on the context of the work (see, for example Garcia, 1996; Isin & Turner, 2007). In the context of narrative engagement in social and health care settings, citizenship can be understood from a micro-citizenship and relational lens (Baldwin & Greason, 2016). Citizenship as a relational practice asserts that citizenship can be "helped, hindered, sustained or undermined through the nature of those relationships" (Baldwin & Greason, 2016, p.291; Brannelly, 2011). In this conceptualization of citizenship, the focus is on the nature of relationships, rather than inclusionary or exclusionary criteria, which can be used to foster a sense of identity and belonging (Baldwin & Greason, 2016; Barnes et al., 2004). When the individuals we work with are seen and understood as citizens rather than "clients" or "patients" a shift in power dynamics occurs where the individual becomes an equal within the relationship (Baldwin & Greason, 2016). In this way, the individual within the social and health care settings contributes as much as they receive (Baldwin & Greason, 2016, p. 298).

A micro-citizenship approach to social and health care is also useful in understanding and conceptualizing citizenship. "The term micro-citizenship refers to those actions and practices of individuals, in immediate relationship, which uphold the liberties and freedoms of those involved while generating or supporting a sense of identity and belonging" (Baldwin & Greason, 2016, p. 293). A micro-citizenship approach requires not only a relational component but also calls for changes in organizational culture and function (Baldwin & Greason, 2016). Of course, from a social worker lens I particularly appreciate this component of citizenship. First, it calls on workers in social and health care to shift how they approach and engage individuals in order to promote and strengthen personal

identity, health, and well-being (Baldwin, 2015) through narrative engagement grounded in citizenship. Second, it also encourages workers to reimagine and advocate for change in systems and organizations, which will foster and promote the inherent dignity, worth, rights, and freedoms of all people.

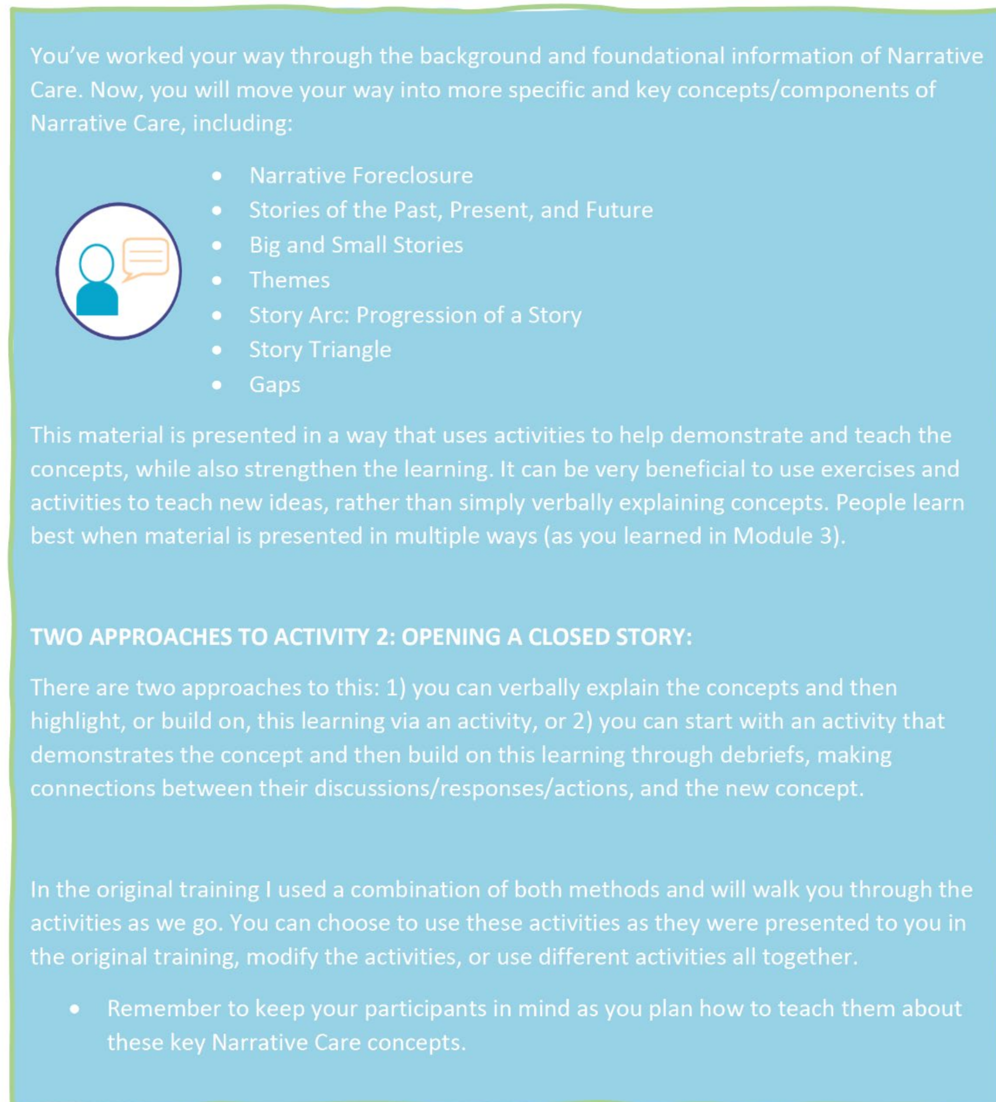
While the possibilities of adopting a narrative care and engagement approach in social/health care to promote social justice is enticing, to date, the application of narrative care is nearly absent in broader social and health care settings. A lot of the work on narrative care has been done in LTC, aging, in the context of working with those living with dementia, and in palliative care (Berendonk et al. 2019; Berendonk et al. 2017; Stanley & Hurst, 2011). There is also some literature exploring the application of narrative care in health/hospital settings (Schdat, 2022) and in working with neurodivergent individuals (Meininger, 2010; Hussain & Raczka, 1997). However, I argue based on the above explorations of a small story narrative care and engagement approach this could, and should, be an effective and empowering method of working with a variety of individuals, and in various practice settings of health and social care. In order for social/health care workers to be able to engage in an applicable and meaningful small story approach to narrative care, foundational knowledge and practical applications of the theory are required. Few, if any, comprehensive training materials exist in the literature for health/social care workers to effectively implement narrative care training or engagement within their workplaces. Recognizing this as a significant barrier to being able to practice small story narrative care and engagement in social and health care, a training program was developed to help fill this gap and to help foster meaningful narrative care and engagement in diverse social and health care fields.

TRAIN-THE-TRAINER PROGRAM

Given the limited opportunities for training in this area, the training program was initially designed in such a way that I, or someone trained, would deliver the initial level of training to a small group of interested social and health care workers. The intention was that the participants would return to their organizations and use their training to organize and facilitate Narrative Care interventions and/or deliver the training for others in their organizations (hence the "train-the-trainer"). Two manuals were created to meet the needs of the training. First, a participant manual, or workbook, and second, a facilitators manual. Because one of the goals of the training was to act as a cascading model, that is, participants return to their organizations and provide training for others, the facilitator's manual was designed in a way that would help "walk the individual" through leading the

training activities, discussions, and more, for others. It follows the design of the participant manual, but with "tips and tricks," to assist with facilitation (see Figure 1).

Figure 1. Example from facilitator manual



Modular design

The train-the-training program was designed as three modules, to allow for optimal flexibility for organization and worker needs, with the main narrative care training being covered in modules one and two, and the program design and implementation material organized in module three. The table below provides a brief overview of each module (see table 1). There is also an additional resource booklet containing numerous additional exercises, activities, and reflection opportunities that participants may choose to use or adapt in their efforts to facilitate narrative care in their respective organizations. The training is, of course, designed with narrative at the heart, which means the facilitation is very activity-based, experiential, and interactive, grounded in stories and engagement in small and large groups. This is also why each training module takes approximately 4 hours, as a lot of time is built in for sharing and engagement. In this way, participants learn from one another's stories and experiences. A safe environment is created to foster and encourage exploration of the self and identity creation, which will ultimately benefit future narrative care and engagement interactions and initiatives between the social/health care workers and those they interact with.

Table 1. Module overview

	Content/Topics	Time-Commitment
Module 1: Foundations of Narrative Care	Background terminology and important concepts including, but not limited to: gerontology, narrative gerontology, narrative care, big and small story approaches, narrative foreclosure, themes, story arc and story triangle, gaps and biases. Participants will have the opportunity to explore critical narrative care concepts as they relate to their personal and professional experiences and explore how their identities impact their engagement with others.	~ 4 hours
Module 2: Narrative Care Begins at Home	Exploring and recap of module one and discussing benefits of narrative care. Exploring key concepts including, but limited to: lifestory, life history, caring listeners as the heart of narrative care and strategies for effective storylistening, meaning vs. fact, restorying. Participants will have the opportunity to practice being caring listeners as well as story sharers.	~ 4 hours

	*If not completing module 3, participants will engage in reflection and discussions about how they envision adopting narrative care and engagement in their practice in meaningful and practical ways going forward (this will look different for each participant).	
Module 3: Designing a Narrative Care Initiative for Your Organization	This module is designed for participants who would like to design (and implement) a more comprehensive and in-depth narrative care initiative in their organization, which requires greater planning than module 2 alone allows. We will explore and work through a planning template, focusing on important aspects of planning including, but not limited to: participants, timing and availability, chosen activity, rationale, materials and resources, budget, SMART objectives, and evaluation. Participants will have the opportunity to fill in, and plan for, their organization and initiative. Before completing the module, each participant will share their vision and receive feedback and comments from the facilitator and other participants. There will be lots of time for discussions, questions, and creativity!	~ 4 hours

An important benefit of module design is that it allows for the training to be conducted over a series of half-days, with the material building upon itself, rather than consecutively, which was critical given the demographic we will engage in the training. As we know, it can be challenging for frontline staff in health and social care to get time away from work to engage in training or workshops (Coventry et al. 2015; Ikenwilo & Skatun, 2014; Harding et al., 2014). Further, the module design gains strength in its ability to offer flexibility in content delivery. For example, some individuals may only be interested in the narrative care training (modules one and two), and not interested in the design and implementation components (module three), which can be easily accommodated with the module approach. For example, workers/volunteers will participate in module one, a four-hour training, and then return the following week to take part in module two, a subsequent four-hour training, which builds on the first. Depending on the interest of the group, they may return for a final, and third, module (also four hours), which is created more specifically to prepare individuals to design and implement a larger (more in-depth) narrative initiative in their organization. During both, the piloting and initial deliveries of the training, individuals seem most interested in modules one and two, which have a particular focus and emphasis on a small story approach to narrative care and engagement, while module three is more focused on big story initiatives and program delivery

(e.g. biographical workshops; reminiscent work; incorporating narrative into admissions; weekly story groups, etc.).

Having worked in health and social care settings, I understood that most (if not all) social and health care organizations are burdened by limited financial and personnel resources, which has only been exacerbated since the Covid-19 pandemic (Crowe et al. 2021; Lavoie-Tremblay et al., 2021; Alami et al. 2021). Thus, the goal of the training is to meet the workers where they are, so that what resonates with them from the training can become part of their stories and used to honour, encourage, and promote the stories of those they are working with. This aspect of training and narrative care is critical for effective and meaningful application of the approach on the frontline, as narrative care is about finding ways to explore and appreciate the stories that make up who the individual is and creating opportunities to both honour existing stories/experiences and to create new ones.

While there is undoubtedly a place for, and benefit to, adopting big story approaches to narrative care in social and health care, and I would never want to see these initiatives cease in practice, there is also great potential in empowering frontline social/health care workers with an understanding of and appreciation for a small stories approach to narrative care and engagement. As Freeman (2011) states, integrating big and small stories are necessary to truly understand the "whole story" of who someone is (p.114). However, given the limited application of small story narrative care approaches in social and health care settings to date, the lack of available training on narrative care generally, and the limited time/resources available to most social/health care workers, the narrative care training program introduces, emphasizes, and explores the benefits and possibilities of adopting a small story approach to narrative care and engagement in their practice. Narrative care risks being ineffective and tokenistic, in addition to becoming a burden to workers, if it is not adopted and embodied in authentic and meaningful ways, which a small story approach better supports.

CONCLUSION

For meaningful small story approaches to narrative care and engagement to be adopted in practice, health/social care workers must have the opportunity to learn about the foundations of narrative care generally, and the benefits of small story engagement and care specifically. Incorporating a small story approach to narrative care on the frontlines would complement existing or new big story initiatives (Freeman, 2011) fostered by others who have increased time and capacity beyond the scope

of those on the frontlines. The train-the-trainer narrative care and engagement program explored above aims to initiate this learning. It is my hope that as the training expands in delivery and continues to be evaluated and revised it will help social and health care workers in diverse practice fields to appreciate and adopt a small story narrative care and engagement approach in their work.

While big story narrative care has radically improved and shifted care approaches, and has a place in social/health care, expanding to include narrative engagement is helpful to broaden the application to include an understanding of power dynamics, rapport, and reciprocity. The adoption of narrative engagement alongside narrative care allows for more flexibility, personalization, and authenticity in the conceptualization of a small stories approach to narrative, which better suits diverse social and health care settings. Narrative engagement also moves beyond simply "asking" towards "acting," and embodying the method in the "mundane" day-to-day social interactions. In these ways, individuals accessing social and health care services have more of a voice and are provided with space and opportunity to become active participants in their stories and experiences. This results in greater opportunities for narrative agency and identity, which leads to empowerment. Embodying narrative engagement in authentic and meaningful ways also promotes citizenship and advocacy for systemic change, encouraging the inherent dignity, worth, rights, and freedoms of all people to be upheld, while also strengthening personal identity, health, and well-being (Baldwin, 2015) through narrative. These outcomes are arguably mutually beneficial for both the worker and those they interact with, fostering positive workplace cultures through advocacy and a shift toward more inclusive, equitable, just, and sustainable social and health care services, grounded in the appreciation and promotion of stories and narrative identity.

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