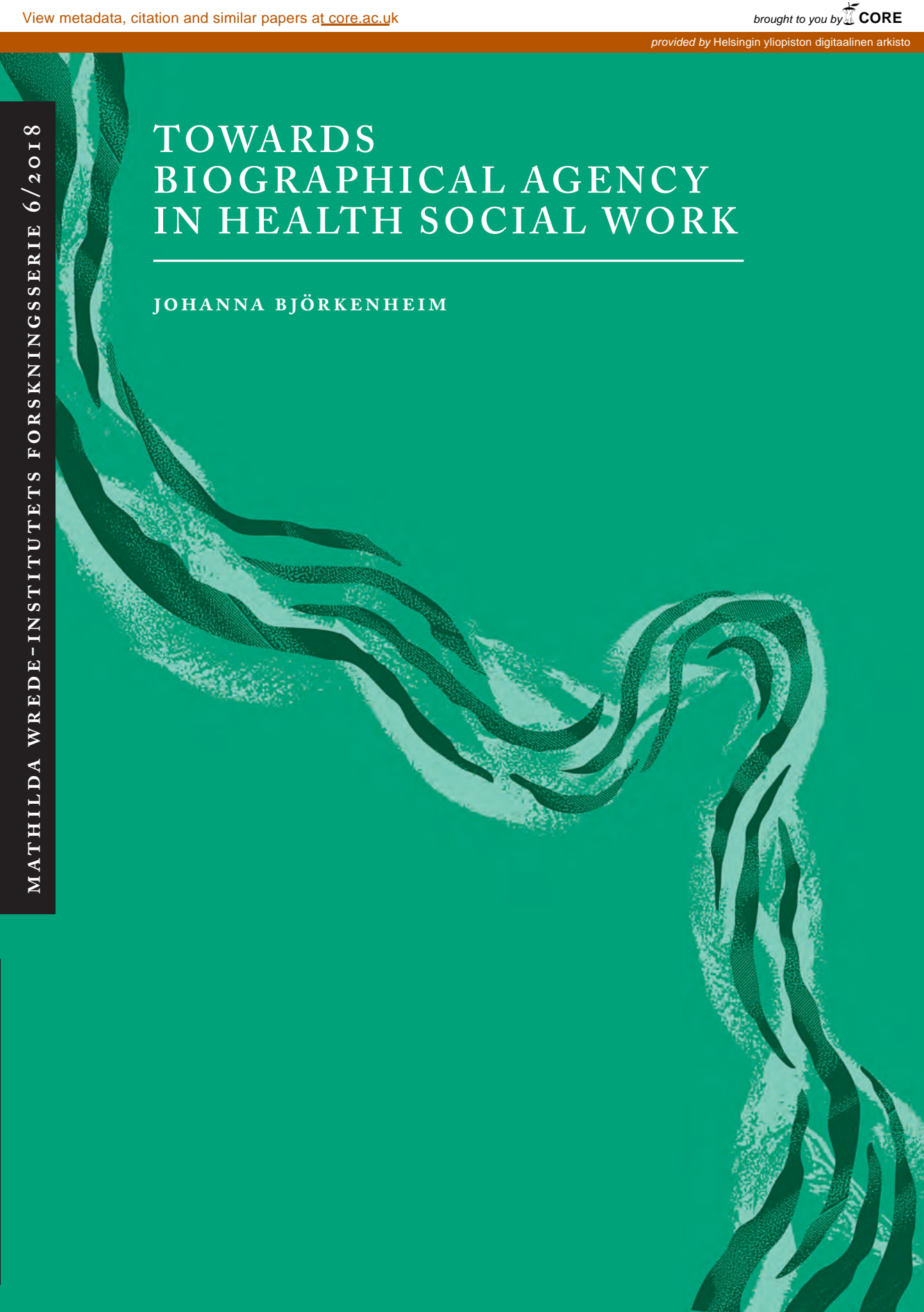


TOWARDS BIOGRAPHICAL AGENCY IN HEALTH SOCIAL WORK

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Towards biographical agency in health social work

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Towards biographical agency in health social work

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List of original publications

The dissertation is based on the following sub-studies,
which I refer to by their Roman numerals:

- I Björkenheim, Johanna (2007) Knowledge and Social Work in Health Care – The Case of Finland. *Social Work in Health Care*, Volume 44, Number 3, pp. 261-278. DOI: 10.1300/J010v44n03_09.
- II Björkenheim, Johanna & Karvinen-Niinikoski, Synnöve (2009) Social Constraints and the Free Will – Life Course and Vocational Career *European Studies on Inequalities and Social Cohesion* 1-2/2008, pp. 103-112. ISSN: 1734-6878.
- III Björkenheim, Johanna & Karvinen-Niinikoski, Synnöve (2009) Biography, Narrative, and Rehabilitation. *European Studies on Inequalities and Social Cohesion* 1-2/2008, pp. 113-127. ISSN: 1734-6878.
- IV Björkenheim, Johanna & Levälähti, Johanna & Karvinen-Niinikoski, Synnöve (2009) Social Work Case Analysis of Biographical Processes. *European Studies on Inequalities and Social Cohesion* 3-4/2008, pp. 123-146. ISSN: 1734-6878.
- V Björkenheim, Johanna (2014) A Social Work Perspective on the Biographical Research Interview with Natalia. On-line journal *Qualitative Sociology Review*, Volume X, Issue 1, pp. 104-115. ISSN: 1733-8077. Article published in German in 2017 as *Biografieorientierte Gesprächsführung in der praxis Sozialer Arbeit*. In B. Völter & U. Reichmann (Eds.), *Rekonstruktiv denken und handeln. Rekonstruktive Soziale Arbeit als professionelle Praxis. Rekonstruktive Forschung in der Sozialen Arbeit*, Band 14. Opladen, Berlin, Toronto: Verlag Barbara Budrich, pp. 269-283. ISBN 978-3-8474-0060-8.
- VI Björkenheim, Johanna (2016) Does past life matter? Social workers' views on biographical approaches. *European Journal of Social Work*, Volume 19, Number 2, pp. 171-186, DOI: 10.1080/13691457.2015.1022860. Published online: 23 Mar 2015.

Abstract

Johanna Björkenheim

Towards biographical agency in health social work

In aiming to help service users cope with a major life change imposed by, for example, a serious chronic illness or a severe impairment, social workers working in health and mental health often, although not always explicitly, take a biographical perspective. Biography, shaped over time through the interplay between human agency and social structure, seems a relevant concept for social work, which focuses on the relationship between the individual and society. The aim of my research was to make the biographical perspective in health social work more explicit and to suggest ways in which practitioners can take into account their clients' past without sliding into the field of psychotherapy. The questions set for the summary article ask what applying the biographical perspective in health social work practice could imply, and whether this perspective is compatible with social work practice theory. The study positions itself within the field of research on theoretical frameworks and knowledge production for health social work practice.

Six papers, published during the years 2007–2016, form the base for this thesis. The first sub-study, focusing on health social work, was based on a survey exploring issues of knowledge and competence, and laid out the context for the biographical perspective in social work practice as presented in the other five sub-studies. Three of the sub-studies were conceptual and published within an educational curriculum in the EU research project INVITE – New Ways of Biographical Counselling in Vocational Rehabilitative Training. The last two sub-studies were empirical and use qualitative content analysis; one analyses a biographical research interview from a social work perspective, and the other presents an analysis of 16 social workers' views on biographical approaches as expressed in their final essays of a course on the biographical perspective in social work practice. Drawing on the sub-studies and on additional literature, the summary article takes the conceptual analysis further by outlining biographically informed health social work practice using ideas, concepts and methods developed in biographical research.

My research maintains that the biographical perspective in health social work practice can be expressed by the notion of supporting clients' biographical agency. This idea provides a general perspective for viewing clients as not totally determined by their

past but as biographical actors in their social world, with a future they can influence. It is argued that the general concept of supporting biographical agency can be used when working with different types of clients in different health social work situations and with a different amount of biographical interviewing. Supporting biographical agency implies listening to clients' life stories, encouraging their biographical work, and helping them reconstruct their biographical identity in the midst of a major life change. In this type of work, building trustful relationships is essential.

I found the biographical perspective in social work practice to be compatible with several social work practice theories. It is by definition compatible with the life course, narrative, reconstructive and relationship-based approaches. I also found it quite compatible with the strengths perspective, person-centred practice, and the empowerment, existential, psychodynamic and ecosystems approaches. However, it was not compatible with the problem-solving and behavioural approaches. Combining different practice theories may also be possible as, for example, in multitheoretical practice. The ethical issues in biographical approaches concern the interpretation of clients' life stories and the risk of clients becoming stuck in their past and possibly expecting psychotherapeutic help.

The conclusion of my research was that the biographical perspective, defined in terms of supporting clients' biographical agency, can provide a useful framework for health social work practice in a multidisciplinary environment. Further research is needed to examine the benefits and possible risks of biographical approaches and to explore, in particular, clients' own experiences of such approaches.

Key words:

health social work, biography, life story, biographically informed practice, biographical agency, biographical work, biographical identity

Sammanfattning

Johanna Björkenheim

Towards biographical agency in health social work

Mot biografiskt agenskap i socialt arbete inom hälso- och sjukvård.

I arbetet med att stödja personer som drabbats av en livsförändring orsakad av till exempel en allvarlig kronisk sjukdom eller funktionsnedsättning använder sig socialarbetare i hälso- och sjukvård ofta av ett mer eller mindre uttalat biografiskt perspektiv. Biografi, som skapas i samspelet mellan mänskligt agenskap och sociala strukturer, framstår som ett relevant begrepp i socialt arbete där man fokuserar på spänningsfältet mellan individ och samhälle. Avsikten med min forskning var att göra det biografiska perspektivet tydligare så att socialarbetare mer uttalat kan ta i betraktande sina klienters förflutna utan att halka in i det psykoterapeutiska fältet. I min sammanfattande artikel diskuterar jag vad ett biografiskt perspektiv kan innebära i socialt arbete i hälso- och sjukvård och hur ett sådant perspektiv passar ihop med det sociala arbetets praktikteorier. Undersökningen positionerar sig inom det forskningsfält som gäller teoretiska ramar och kunskapsproduktion för socialt arbete i hälso- och sjukvård.

Sex artiklar, publicerade under åren 2007–2016, utgör grunden för min avhandling. Den första delstudien handlar om socialt arbete i hälso- och sjukvård och bygger på enkätsvar om socialarbetares syn på kunskap och kompetens. Artikeln ritar upp landskapet för en diskussion om det biografiska perspektivet i socialt arbete, vilket behandlas i de övriga fem delstudierna. Tre av delstudierna var begreppsliga och publicerades som delar av ett utbildningsmaterial inom EU-projektet INVITE – New Ways of Biographical Counselling in Vocational Rehabilitative Training. De två sista delstudierna var empiriska och använder kvalitativ innehållsanalys. I den ena analyseras en biografisk forskningsintervju från ett socialarbetarperspektiv och i den andra diskuteras 16 socialarbetares synpunkter på biografiska tillvägagångssätt utifrån deras slutessäer på en kurs om det biografiska perspektivet i socialt arbete. I den sammanfattande artikeln, som bygger på delstudierna och ytterligare vetenskaplig litteratur, för jag den begreppsliga analysen vidare och skisserar upp vad det biografiska perspektivet i socialt arbete inom hälso- och sjukvård kunde innebära utifrån idéer, begrepp och metoder som utvecklats i biografisk forskning.

I min forskning gör jag gällande att det biografiska perspektivet i socialt arbete i hälso- och sjukvård kan sammanfattas i begreppet att stödja klienters biografiska agentskap. Idén erbjuder ett allmänt perspektiv för att betrakta klienters liv som inte helt förutbestämt av det förflutna utan även för att se klienterna som biografiska aktörer i sin sociala värld med en framtid som de själva kan påverka. Jag hävdar att ett biografiskt perspektiv, så definierat, kan användas i arbetet med olika slags klienter i olika situationer och med biografiska intervjuer av olika omfattning. Att stödja klienters biografiska agentskap innebär att lyssna till deras livsberättelser, uppmuntra deras biografiska arbete och hjälpa dem att rekonstruera sin biografiska identitet vid en större livsförändring. I detta arbete är det nödvändigt att kunna bygga upp förtroendefulla relationer.

Det biografiska perspektivet i socialt arbete befanns passa ihop med flera praktikteorier i socialt arbete. Per definition är det kompatibelt med livsloppscentrerat, narrativt, rekonstruktivt och relationsbaserat socialt arbete. Det befanns också vara rätt så kompatibelt med resurs-, empowerment-, existentiellt, psykodynamiskt, ekosystemiskt och personcentrerat socialt arbete. Däremot passar perspektivet inte ihop med socialt arbete inriktat på problemlösning eller beteendemodifikation. Olika praktikteorier kan dock kombineras t.ex. i multiteoretisk praktik. De etiska aspekterna i biografiska tillvägagångssätt gäller bland annat hur klienters livsberättelser tolkas och risken för att klienterna fastnar i sitt förflutna och kanske förväntar sig psykoterapeutisk hjälp.

Slutsatserna av min forskning var att det biografiska perspektivet, definierat som stöd för klienters biografiska agentskap, erbjuder en användbar teoretisk ram för socialt arbete i mångdisciplinär hälso- och sjukvård. Ytterligare forskning behövs för att undersöka fördelar och eventuella risker med biografiska tillvägagångssätt och framför allt för att klarlägga klienternas egna upplevelser av dem.

Nyckelord:

socialt arbete; biografi; livsberättelse; biografiskt perspektiv; biografiskt agentskap; biografiskt arbete, biografisk identitet

Tiivistelmä

Johanna Björkenheim

Towards biographical agency in health social work

Kohti elämäkerrallista toimijuutta terveystieteissä.

Pyrkinessään tukemaan terveydenhuollon asiakkaita vakavaan pitkäaikaissairauteen tai vaikeaan vammaan sopeutumisessa terveystieteiden ammattilaiset usein, toisinaan jopa huomaamattaan, käyttävät elämäkerrallista näkökulmaa. Elämäkerta, joka muotoutuu ajan myötä toimijuuden ja sosiaalisten rakenteiden välisessä vuorovaikutuksessa, vaikuttaisi olevan käyttökelpoinen käsite yksilön ja yhteiskunnan väliseen suhteeseen keskittyvässä terveystieteissä. Tutkimukseni tavoite oli elämäkerrallisen näkökulman selventäminen niin, että terveystieteiden ammattilaiset voisivat tietoisemmin ottaa huomioon asiakkaittensa menneisyyttä siirtymättä kuitenkin psykoterapeuttiseen työskentelyyn. Yhteenvetoartikkelini tutkimuskysymykset koskevat sitä, mitä elämäkerrallinen näkökulma voisi tarkoittaa käytännön terveystieteissä ja miten tämä näkökulma sopii yhteen terveystieteen käytäntöteorioiden kanssa. Tutkimus paikantuu terveystieteiden teoreettisten viitekehyksen ja tiedontuotannon kenttään.

Vuosina 2007-2016 julkaistut kuusi artikkelia muodostavat väitöskirjan perustan. Ensimmäinen osajulkaisu käsittelee kyselyaineiston perusteella tietoa ja kompetenssia terveystieteissä ja luo keskustelupohjaa elämäkerralliselle lähestymistavalle, jota käsitellään viidessä muussa osajulkaisussa. Osajulkaisuista kolme ovat käsitteellisiä ja julkaistiin osana opetusaineistoa, joka tuotettiin EU tutkimusprojektissa INVITE – New Ways of Biographical Counselling in Vocational Rehabilitative Training. Kahdessa viimeisessä osajulkaisussa käsitellään aihetta empiirisesti käyttäen kvalitatiivista sisällönanalyysiä. Toisessa analysoidaan erästä elämäkerrallista tutkimushaastattelua terveystieteen näkökulmasta ja toisessa analysoidaan 16 terveystieteiden elämäkerrallista lähestymistapaa käsittelevän kurssin loppuesseitä siitä näkökulmasta, miten niissä arvioidaan ko. lähestymistavan hyötyä terveystieteissä. Osajulkaisuihin ja lisäkirjallisuuteen nojaten teoreettis-käsitteellinen analyysi viedään yhteenvetoartikkelissa pidemmälle hahmottelemalla elämäkerrallista lähestymistapaa terveystieteissä. Tässä analyysissä käytän elämäkertatutkimuksessa kehitettyjä ajatuksia, käsitteitä ja menetelmiä. Tutkimukseni tuloksena tiivistän elämäkerrallisen lähestymistavan terveystieteissä käsitteeksi elämäkerrallisen toimijuuden tukeminen. Tämä ajatus tarjoaa yleisen lähestymistavan asiakkaiden näkemiseksi ei täysin menneisyytensä määrittäminä vaan myös elämäkerrallisina toimijoina sosiaalisessa maailmassaan, jossa he voivat vaikuttaa omaan tulevaisuuteensa. Väitän, että elämäkerrallisen toimijuuden tukemisen käsitettä voidaan käyttää

erilaisten asiakkaiden kanssa työskenneltäessä erityyppisissä keskusteluissa ja eripituisissa elämäkertahaastattelussa. Asiakkaiden elämäkerrallisen toimijuuden tukeminen tarkoittaa heidän elämäkertomustensa kuuntelemista, elämäkerralliseen työskentelyyn rohkaisemista ja heidän vahvistamistaan elämäkerrallisen identiteetin jälleenrakentamisessa merkittävän elämänmuutoksen yhteydessä. Siinä työssä tarvitaan luottamuksellisen suhteen rakentamisen taitoa.

Sosiaalityön elämäkerrallista lähestymistapaa todettiin voitavan hyvin käyttää usean sosiaalityön käytäntöteorian kanssa. Määritelmällisesti se sopii yhteen elämänkulkukeskeisen, narratiivisen, rekonstruktiiivisen ja suhdeperustaisen sosiaalityön kanssa. Lähestymistapa todettiin myös olevan melko yhteensopiva voimavarasuuntautuneen, valtaistavan, eksistentiaalisen, psykodynaamisen, ekosysteemisen ja henkilökeskeisen sosiaalityön kanssa. Se ei kuitenkaan sovi ongelmanratkaisukeskeisiin tai käyttäytymisteoreettisiin lähestymistapoihin. Mutta erilaisia käytäntöteorioita voidaan yhdistää esimerkiksi moniteoreettisessa sosiaalityössä. Elämäkerrallisten lähestymistapojen eettiset näkökohdat koskevat muun muassa asiakkaiden elämäkertomusten tulkintaa ja heidän menneisyyteensä juuttumisen riskiä sekä heidän mahdollisia odotuksia psykoterapeuttisen avun saamiseksi.

Tutkimukseni johtopäätöksenä esitän, että elämäkerrallinen lähestymistapa määriteltynä asiakkaiden elämäkerrallisen toimijuuden tukemisenä voisi tarjota hyödyllisen teoreettisen kehyksen monitieteisen terveydenhuollon sosiaalityöhön. Lisää tutkimusta tarvitaan sosiaalityön elämäkerrallisten lähestymistapojen hyödyistä ja mahdollisista riskeistä. Erityisesti tulisi selvittää asiakkaiden omia kokemuksia tällaisten lähestymistapojen käytöstä.

Avainsanat:

terveyssosiaalityö; elämäkerta; elämäkertomus; elämäkerrallinen lähestymistapa; elämäkerrallinen toimijuus; elämäkerrallinen työskentely; elämäkerrallinen identiteetti

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This is not a life story, but the story of a long PhD journey, and a story about those who helped push the journey forward. There are many people to whom I owe great thanks for helping me reach the end of this journey. The two who deserve my deepest gratitude are my supervisors over all these years, Synnöve Karvinen-Niinikoski and Pirkko-Liisa Rauhala. Without them this thesis would still not be completed. Synnöve recruited me to the university in 2001 and asked me to join the two research projects that formed the base of my thesis research. Her knowledge of social work research has been crucial. Pirkko-Liisa has been essential for keeping the process going and helping me manage the academic format. Both have persistently and patiently showed a never-ending interest in my work and encouraged me to finish my thesis even when it was clear that a PhD would no longer serve to advance my vocational career because I was already retired. I am glad their persistence has now been rewarded.

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The two main themes of my research, knowledge in health social work and biographically informed social work practice, developed thanks to two research projects. The Konstikas research team under project leader Synnöve Karvinen-Niinikoski: Tero Meltti, Jari Salonen, Maria Tapola-Haapala and Laura Yliruka deserve my warm thanks for all their excellent work and collaboration. The EU research project INVITE, with participants from six countries inspired me to more specifically define my thesis research interest. For the enjoyable and productive collaboration in the project I am deeply grateful to all the participants, most importantly Fritz Schütze, Gerhard Riemann, Peter Straus, Aled Griffiths, Richard Barker, Sandra Betts, Agnieszka Golczyńska-Grondas, Synnöve Karvinen-Niinikoski, Mirjam Kalland, Johanna Levälähti and Eila Sundman. Later Kaja Kaźmierska kindly advanced my research on biographical approaches in different ways; for this I am also very grateful. I wish to thank Richard Barker, Pia Eriksson, Lucy Hyland, Kirsi Nousiainen, Ute Reichmann and Gerhard Riemann for taking the time to comment on different parts of my texts.

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Espoo, February 2018
Johanna Björkenheim

1 Introduction

The users of social work services are often in a situation that requires them to review their life and to try to find new ways in which to proceed. This is also true for users of health care services. For example, people who have been brain-damaged in a car accident or diagnosed with a chronic, maybe life-threatening, illness; people whose work capacity has deteriorated for other reasons; or people who have problems managing their everyday life due to old age might benefit from a biographical approach in preparing for the major life change imposed by their new situation. Social workers may also be presented with their clients' life stories without explicitly asking for them, and thus be pushed into taking a biographical approach.

Drawing from ideas, concepts and methods developed in biographical research, the aim of my research has been to explore how generalist health social workers¹ can take the lived and told lives of patients into account when dealing with their present situation and helping them plan for their future. This study focuses primarily on social work in health care due to my own work experience in this field, but a discussion on biographical perspectives and approaches is likely to also be relevant for other social work settings.

My research positions itself within the field of research on theoretical frameworks and knowledge production for social work in health care. Six papers, published during the years 2007–2016, form the base for my thesis; this summary article places the scope and results of the sub-studies, referred to by the Roman numerals I–VI, into a wider context of research through a conceptual study on the implementation of a biographical perspective in health social work practice. Sub-study I explores health social workers' views of knowledge in general; Sub-studies II–VI deal more specifically with biographical approaches and discuss different aspects of the biographical perspective in relation to social work in general. By including Sub-study I in my thesis, I want to focus the discussion in this summary article on the context of social work performed in health care settings.

1 'Generalist' social work in this context refers to social work tasks and methods of a varied nature, and to clients with a great variety of, often quite complex, problems (DuBois & Miley 2005, 9–10) as opposed to, for example, addiction treatment units, where specific work methods may be used with selected client groups for working on specific problems (Miller & Rollnick 1991). On the other hand, health social work itself can be regarded as a field of specialisation requiring vast knowledge of societal and organisational resources, social legislation, and rehabilitative and other services, as well as understanding of the impact of severe health problems on people's lives (cf. Metteri 2014). Furthermore, particularly in large university hospitals, health social workers often specialise by working with certain patient groups and their specific problem situations.

Synnöve Karvinen-Niinikoski, co-author of the conceptual Sub-studies II–IV, provided valuable comments on the texts while in progress; she was in charge of the Finnish regional project of the EU research project INVITE – New Ways of Biographical Counselling in Vocational Rehabilitative Training under the Leonardo da Vinci programme, which produced these sub-studies. Johanna Levälähti, second co-author of Sub-study IV, wrote Section 4 of the sub-study.

Social work is often said to be practised on the basis of intuition or ‘gut feeling’ (term used by Martinell Barfoed & Jacobsson 2012, 10), even though recent years have seen a great effort to make social work practice more theory- and research-based (Healy 2014; Karvinen-Niinikoski 2005). Social workers are known to be eclectic with theories, mixing different ones without necessarily distinguishing between them (Payne 2005, 30–32). Gut feelings should not be underestimated, as they can constitute valuable tacit knowledge. However, as Karen Healy (2014, 22–24) points out, social workers should work on improving their capacity to identify, use and develop formal social work theory in their practice because this is necessary to increase the accountability for service users and other stakeholders, to improve service quality and to develop a formal theoretical base for the social work profession. For social workers’ informal knowledge to be transparent and useful to others, their theoretical assumptions must be explicated and critically examined, Healy argues.

Also in health care services, social workers use and create knowledge based on theoretical assumptions. Although explicit dealing with clients’ life stories is not rare in social work practice (e.g., Ellem & Wilson 2010; van Puyenbroeck & Maes 2006; Sub-study IV), implicit theoretical assumptions based on the biographical perspective are also likely to be quite common (e.g. Kyllönen 2004). Considering that most social workers often deal with information about their clients’ past lives and listen to their life stories, it is surprising that so little is mentioned in social work textbooks about the interventive effect of eliciting biographical information (cf. Bornat 2004; Golczyńska-Grondas & Grondas 2013; Rosenthal 2003). The aim of my research is to promote more clarity in the implementation of biographical approaches in generalist health social work practice.

My interest in the biographical perspective started in the 1980s, when, working as a university hospital social worker, I met patients who had been diagnosed with end-stage renal disease and whose lives had been completely changed by having to undergo essential treatments, in the form of dialysis and renal transplantation, for the rest of

their lives. The theories informing Finnish health social work at the time, such as crisis theory (Cullberg 2006), adaption/grief theory (Kübler-Ross 1969) and life quality theory (Landhäußer & Ziegler 2005), did not seem sufficiently helpful for supporting renal patients in adjusting to the major long-term life change required (cf. Forinder & Olsson 2014; Jeppsson Grassman et al. 2012). At that time, working on my Master's thesis (Björkenheim 1992), I came across life history research (Roos 1985) and decided to study how the biographical disruption (Bury 1982) of the lives of people beginning maintenance dialysis treatment affected their daily lives and future outlooks.

Later, working in a rehabilitation assessment unit at the same university hospital, I was a member of an interprofessional team that assessed the employment capacity of people suffering from complex medical, (neuro)psychological, social and other problems, and made rehabilitation plans for them. As a social worker, I had the task of eliciting life history information from the service users as part of an extensive psychosocial assessment. Despite my previous experience of life history interviewing for research, I felt that detailed biographical interviewing in social work practice indeed required a different approach (cf. Sub-study V). At the time, Finnish health social workers were looking for ways to systematise and structure their practice. As part of this work, extensive questionnaires were created for use in rehabilitation assessment (Terveyssosiaalityön... 2007, 14). However, for the purpose of encouraging clients to speak freely about the issues they themselves found most essential and for building the trustful client/worker relationship required for this, an open interviewing technique seemed more productive. In my work, I also saw that the very autobiographical storytelling often had a positive effect on the narrator (cf. Rosenthal 2003).

Later, participating in the European INVITE research project on biographical counselling in vocational rehabilitation, I had the opportunity to learn more about the concepts and methods used in biographical research and to study further what social work practice could gain from these (Sub-studies II–IV). In my work as a university teacher, I could also teach biographical approaches in social work and further develop my understanding of the biographical perspective together with my students (Sub-study VI). My thesis research has thus emerged slowly over the years, starting with an interest in scientifically exploring my own practical experiences (cf. Karvinen et al. 1999) and gradually deepening into theoretical thinking about the application of the biographical perspective in social work practice.

There were several reasons why I found the biographical perspective interesting for social work practice with people facing a major life change due to serious chronic illness or impairment. According to biographical researchers, a person's present situation is best understood when related to their collected life experiences (Rosenthal 2003), and the meaning of major events in a person's life cannot be understood without knowing at which life stage they occurred and what the political and social conditions were at that time (Jeppsson Grassman et al. 2012). Moreover, when faced with a radical health change, many patients experience a life crisis and want to talk about existential issues (cf. Thompson 2005, 21–24). Autobiographical storytelling has been found to entail so-called *biographical work* (Betts et al. 2009, 26), which is essential when adjusting to a major life change.

Another advantage of the biographical perspective could be that clients' life-story telling generally expresses their own interpretation of their lives, and this interpretation is crucial when making plans for the future. And finally, in a medical and often fragmenting setting, social workers are expected to provide a holistic view of the patient in their social world (Forinder & Olsson 2014; Korpela 2014; Ma 1997). *Biography* has been presented as a holistic concept in that it contains both structure and human agency, as well as the temporal dimension (Miller 2000, 74–75). In the extensive reorganisation of Finnish social welfare and health care services (Sote) which is currently underway, biographically informed social work practice could emphasise a holistic view of service users as individuals with individual needs, instead of viewing users as merely pieces to move around within the system.

Descriptions of professional practice with a biographical perspective use different expressions, such as biographically informed practice/work (Apitzsch et al. 2004, 7), biographically focused professional practice (ibid., 1) and biographical practice (Bornat & Walmsley 2004, 229). Other, more specific, expressions are, for example, biography work (Roer 2009), biographical counselling (Betts et al. 2009) and life story work (Ellem & Wilson 2010). For the context of health social work in general settings, I choose to use the expression of biographically informed social work practice, because it is general enough to allow a wider understanding of biographical practice.

The two research questions set for this summary article focus on exploring what applying a biographical perspective in health social work practice might imply, and whether this perspective is compatible with contemporary social work practice theory. Rather than suggesting or formulating a specific biographical intervention method for

health social work practice, my aim has been to highlight biographical ideas, concepts and methods from which health social workers can draw inspiration when developing their practice. In summarising the results of my six sub-studies, I found it relevant to introduce *biographical agency* (cf. Heinz 2009a; 2009b; Hitlin & Elder 2007) as a comprehensive core concept which ties together the biographical ideas presented for health social work practice. As a result of my research, I argue that biographically informed health social work practice can be expressed in the notion of supporting clients' biographical agency.

In health care settings, as in other fields, social work can be practised on a community and society level as well as on an individual level. The focus of my research is primarily on work with individuals, families and groups; I deal with structural factors mainly from the perspective of individual client situations (cf. Pohjola 2014). Because of my own work experience, my focus is on the work with adults. This does not mean that a biographical perspective cannot or should not be used with children or adolescents – quite the contrary (cf. Känkänen & Bardy 2014). However, in child health care, social workers mostly work with the parents, the adults, whereas the children are seen by psychologists. In my research, I do not focus on or exclude any particular patient group, illness or disability, or any particular type of health service organisation. The social worker can decide on the situations in which initiating a biographical approach is relevant. However, in my view, all patients can be considered biographical actors in their social world, having agency that can be supported.

This summary article is organised in the following way: Chapter 2 outlines social work in health care as the context for implementing the biographical perspective. The research problem and methodology are described in Chapter 3. Chapter 4 presents biographical research as the theoretical framework for my research, and Chapter 5 reviews three main types of biographical approaches for professional practice described in the literature. Chapters 6 and 7 deal with my research questions. At the end, I discuss the results and make some concluding remarks.

2 Social work in health care as context for study

Health is an essential dimension of wellbeing. The International Federation of Social Workers (IFSW) describes it as ‘an issue of fundamental human rights and social justice’². Regardless of work setting, health is seen as important in all social work (Beddoe & Maidment 2014; Metteri et al. 2014), not least because social structures impact on health (Rose & Hatzenbuehler 2009). Health care as a setting for social work practice differs from other settings as its primary focus is on health, illness and impairment; social work is not the primary reason for people being admitted to hospital.

Citing Tuula Heinonen and Anna Metteri (2005a), ‘[a] social worker in the field of health or mental health strives to understand and work with people in their situations, applying values that foster wellbeing, healing, growth, and change in individuals, families, groups, and communities’ (p. 2). In Finland, roughly a fifth of all social workers, approximately 1000, are employed in health and rehabilitation services (Metteri 2014). Most of them work in the public health sector, mainly in specialised health care, in both hospitals and out-patient clinics. Health care is also a main employer of social workers in other countries (Beddoe & Maidment 2014; Blom et al. 2014).

The term health care in this context pertains to all multidisciplinary medical settings, whether somatic or psychiatric, primary health or specialised care, hospital-based or home-based, public or private. The literature refers to social work performed in health care and social workers working in health care in different ways. The term medical social work/er (Heiwe et al. 2013) is often replaced by health social work/er (Craig & Muskat 2013), which I prefer because of its less biomedical connotations. More specific terms are used to refer to particular work contexts, for example, hospital social work/er (Judd & Sheffield 2010), rehabilitation social work/er (Miller et al. 1984) and gerontological social work/er (Koenig et al. 2011).

The people whom health social workers meet and aim to help are also described using various terms. There seems to be a tendency, if possible, to avoid using any specific term and instead to talk generally about individuals, persons, adults, families or people. However, sometimes it is necessary to name the recipients of social work services more specifically. The term service user has for some time been more commonly used (cf. Healy 2014; Wilson et al. 2011) than client (cf. Payne 2005). Moreover, the connotations of the terms client, patient, (service) user and customer may differ in different languages. In the Finnish language, for example, ‘asiakas’ means both client and customer (Pohjola 2010) and is thus possibly less stigmatising than the English

2 Retrieved January 28th, 2018, from <http://ifsw.org/policies/health/> 2008, updated in 2012.

term client. The users of health care services are often called patients (Heffernan 2006), even by health social workers themselves (cf. Forinder & Olsson 2014). In this summary article, I generally use the term client, because, unlike service user, client implies a relationship with the worker (Hübner 2014), and in biographically informed social work practice, this relationship is extremely important.

In the following, I discuss the roles, tasks, knowledge and skills of health social workers, and end with a review of how different health paradigms may influence practice. But first, I provide a brief overview of the current discussions in health social work.

2.1 Current discussions

The context of health social work practice has changed rapidly in the last decades. The dismantling of the welfare state, increased demands for cost-effectiveness, measurable positive patient outcomes, and evidence-informed practice (however, for a discussion on the situation in Finland compared to Sweden, see Hübner 2016), as well as funding shortages and demographic changes, create new challenges for health social work (cf. Haultain 2014). Currently topical issues in health social work are dealt with in articles, textbooks, and national and international professional conferences³.

The current themes of interest discussed at professional conferences are, for example, interprofessional collaboration; health equality and the social determinants of health; the use of WHO's (World Health Organization) (2001) International Classification of Functioning, Disability and Health (ICF) as a work tool; disaster mental health; spirituality and palliative care; work with different patient groups and patients with different cultural backgrounds; and various social phenomena such as violence and addiction problems.

In Finland, the planned extensive national social welfare and health care reform (Sote) creates a considerable challenge, as it aims to reorganise and integrate public and private social welfare and health services. The role of health social work in this new

3 The professional conferences studied for this article were the 7th and 8th International Conferences on Social Work in Health and Mental Health in 2013 and 2016 and the Finnish biannual National Conferences on Health Social Work in 2014 and 2016.

system is still an open question. With their knowledge of social welfare and health care services, their understanding of the impact of health issues on people's lives, and their experience of working closely with health professionals, health social workers maintain that in the new integrated system they will play a crucial role by being able to identify patients' psychosocial needs and make holistic rehabilitation plans at an early stage, thus contributing to less suffering among patients and improved cost-effectiveness for society.

As in social work in general (Gitterman 2014; Karvinen-Niinikoski 2005), a main concern in health social work is how to advance the dialogue between research and practice (Metteri et al. 2014). Practitioners are urged to conduct research and develop theory in their field (Morén et al. 2014). Health social workers indeed feel the need for a stronger theoretical base and a clearer professional identity (Sub-study I; cf. Korpela 2014); with the increasing amount of social work research, more studies on health-related issues are being conducted, providing opportunities to develop research-based practice in health social work⁴. Research can help practitioners more successfully claim a space for social work in the medical context and clarify their role and professional competence, both inside and outside their employer organisation (Metteri 2014; Morén et al. 2014).

More effort is needed to combine individual perspectives with social and structural ones (Beddoe & Maidment 2014; Metteri 2012). In practice, the social perspective often involves working with the environment and the social circumstances of individual clients (Pohjola 2014). Structural issues are often addressed by collaborating with patient organisations to advocate for patient groups. When documenting their work or discussing cases in team meetings, health social workers could also attempt to broaden the perspective of patients' individual situations by identifying more of the social circumstances leading to the complex situations (Pockett & Beddoe 2017).

Liz Beddoe and Jane Maidment (2014) see two main areas of professional challenge for health social work: how to work within a political context influenced by the neoliberal discourse and growing poverty, and how to respond effectively to the needs

4 In Finland, recent health social work and related research includes studies on the experience of illness and death (Miettinen 2006; Molander 1999; Rissanen 2015; Ryyänen 2005), patient groups (Hänninen 2004; Kantola 2009; Knuuti 2007; Lillrank 1998; Lindqvist 2014; Siponen 1999; Somerkivi 2000, Vierimaa 2011; Virokannas 2004), work practices (Antikainen-Juntunen 2005; Kokko 2003; Lindén 1999; Metteri 2012; Numminen 2005; Sellergren 2007; Sjöblom 2007), documentation (Günther 2015), multidisciplinary collaboration (Isoherranen 2012), and leadership (Kyyhkynen 2012; Pajula 2013).

of the ageing population. Linda Haultain (2014) suggests developing a learning culture and working with local universities to engage in practice-based research. A new challenge concerns the rapid advances in biomedicine and their effects on health social work practice. Karen Healy (2016) points out the risk that new technology in neuroscience and genetics may lead to the medicalisation of social problems and undermine the psycho-social understanding of and responses to human need.

2.2 Roles and tasks

Social work was introduced into Finnish health care in the 1920s through influences from other countries such as the US, the UK, Sweden, Denmark, Germany, and Switzerland (Hakola 1965). The arguments for social work were economical (more efficient use of hospital beds), preventive (prevention of relapses) and humanistic (more humane care) (Åberg 1942, 31–32; cf. Stuart 2004). The task of the social nurse (as health social workers in Finland were called until the 1970s) was defined as constituting a link between the hospital and the community to ensure that relevant care continued after a hospital stay (Larsson 1945, 76–77). Offering practical help and advice to indigent hospital patients was often seen as an important task (Heinonen & Metteri 2005a) and, alongside relational help, still is (Toikko 2005, 216).

The Finnish Ministry of Social Affairs and Health defines the aim of health care as being ‘to maintain and improve people’s health, wellbeing, work and functional capacity and social security, as well as to reduce health inequalities’⁵. This can be understood as social work playing an important role in health care services but may also be connected more to the national social welfare and health care reform (Sote) plan currently in progress. The authorities have defined health social work as being performed in health care institutions that pursue national social and health policy goals for the benefit of maintaining people’s health and social functioning (Sosiaalityö... 1982, 9–10; Sosiaalityö... 2001, 8).

The mission of health social work, as defined by the Finnish Association of Health Social Workers (Terveyssosiaalityön... 2007, 9), is to prevent marginalisation; to help

5 Retrieved January 28th, 2018, from <http://stm.fi/en/health-services>

patients in concrete problematic situations through guidance, advice and rehabilitative measures; and to promote their general social functioning by providing psychosocial support. No one specific social work practice method is considered superior to other methods. The focus is on the social determinants of health and the consequences of illness and impairment. Health social workers are supposed to work at all levels.

Establishing a clear role for social work in health care and engaging in interprofessional collaboration was not easy in the beginning (Larsson 1945, 77). Health social workers have seen their work change a great deal due to educational, organisational, legal and environmental circumstances, but they have also been able to develop their own work. However, the role of health social work remains unclear, both legally (Metteri 2014) and professionally. This has both positive and negative implications: on the one hand, social workers have some freedom to develop their own role but, on the other hand, organisational interests still strongly determine what they can do. (Davis et al. 2004; Korpela 2014.)

The roles and tasks of health social workers vary in different countries depending on the contextual, organisational and societal circumstances. In Finland and many other countries, the focus is on providing different kinds of material and non-material support (Toikko 2005, 213–221; Wilson et al. 2011, 347) and on advocating patients' rights to services (cf. Levy & Payne 2006; Romakkaniemi 2014). In Sweden, health social workers do not generally work on securing material help and social benefits for patients, nor are they involved in discharge planning, which is an important task of health social workers in most countries; they mainly provide counselling around life situations created by illness (Blom et al. 2014). In the US and Australia, psychotherapy is a social work task and is reimbursed by a third party (cf. Healy 2014, 68).

The general roles of health social workers, as listed by the Finnish Association of Health Social Workers, are those of expert, consultant, therapist, crisis worker, networker, coordinator and rehabilitation contact person (Terveyssozialityön... 2007, 9). These roles partly overlap the self-described roles mentioned in a Canadian study (Craig & Muskat 2013): bouncer, janitor, glue, broker, firefighter, juggler and challenger, which give a somewhat harsher picture of health social work. However, the suggested role of a 'positive heckler' (Laine 2014), balancing between various demands, for Finnish health social workers also highlights the conflicts often inherent in the work.

Social work performed in health care services differs in certain respects from social work performed in the municipal social services, which is the largest employer of social workers in Finland (Sub-study I). One main difference is that in health care, social workers very seldom exert social control as representatives of authority. Most social work clients experience some kind of crisis related to, for example, lack of material resources, drug abuse or relational problems. In addition, in health care, social work clients experience crises caused by illness, impairment and/or death, and health social workers often deal with a complex set of social, physical, psychological, existential and relational aspects of their clients' lives (Blom et al. 2014). The clients represent all socio-economic classes and may have very different types of needs.

A Finnish study (Korpela 2014) found that health social workers consider their most important tasks to be assessing the social situation of clients; providing guidance and advice on social security and social welfare services and, when necessary, assisting clients in applying for these services; planning discharge; participating in multidisciplinary collaboration; networking; and providing psychosocial support. The respondents felt that they could provide more psychosocial support to patients if organisational practices allowed this. They considered building trustful relationships essential for the work to be successful. Psychosocial support, in this context, is understood as the general relational and motivational support of individuals in their social environment.

In doing their job, health social workers depend greatly on collaborating with partners both inside and outside of the organisation. In Finland, medical hegemony is strong; many social security benefits and rehabilitation services require a physician's recommendation, so working relationships with doctors are essential. Working with health professionals in the organisation often takes place in multidisciplinary teams. In most types of collaboration, the multidisciplinary setting challenges social workers' professional self-confidence and identity as well as their professional competence and negotiation skills.

2.3 Knowledge and skills

In health care institutions, social work knowledge is developed through constant interplay with the biomedical and multidisciplinary environment. In a study (Sub-study I), health social workers saw knowledge as both formal (theoretical knowledge), acquired through education, and informal (practical knowledge), acquired through work and life experience. Important knowledge was thought to include the ability to assess the limits of work task as well as the limits of the social worker's own knowledge and competencies (self-regulating knowledge). The health social workers regarded professional competence as implying relational knowledge and skills, taking the time to listen and process with clients and giving them space and options. They also associated knowledge with professional identity and special competence of 'knowing something other professionals do not know' (p. 271).

Scholars of health social work have attempted to define the knowledge base (knowledge as object) and the competences needed in this particular work setting. Joyce Lai-chong Ma (1997) sees the problems health social workers meet as essentially being 'the psychosocial difficulties arising from or in association with illness and disease' (p. 23); the workers have 'to understand the psychosocial consequences of the particular illness on an individual, the family and on society' (p. 23). Besides the social work discipline, health social work draws on many other disciplines as well, such as psychology, anthropology, sociology (ibid., 27), social policy, social psychology, pedagogy, health science, philosophy, law, administration, and economics (Lindén 1999, 53).

For many years, the education of Finnish health social workers developed separately from the education of municipality social workers. In the 1920s, when social work was first introduced into psychiatric, paediatric and surgical care (Hakola 1965), specific health social work education did not exist. The early health social workers were public health nurses or nurses specialised in the very medical field in which they worked (Åberg 1942, 9). In the 1940s, when the first school of social work was founded, developers of health social work felt that the planned education did not meet the needs of the health field. A short specialisation for trained nurses was then introduced, which was later extended to one school year (Ahla 1965).

In 1975, social nursing education was discontinued, as it was considered no longer relevant. From then on, all social workers in Finland, regardless of where they work, have belonged to the same profession. In the 1980s, social work education was taken to the university level, and the formal competency for all social workers is now a Master's degree in Social Science, majoring in Social Work. In 2001, a professional licentiate qualification was launched, and specialisation in rehabilitation and empowerment has been particularly popular among health social workers. Bachelors of social services, who graduate from Universities of Applied Sciences, are a newer group of professionals. They are social counsellors, whose tasks in health care institutions have not yet been clearly defined.

Thus, for several decades, Finland had health social workers of two different educations, almost different schools: on the one hand were social nurses, whose professional knowledge was built mainly on caring and individual casework; and on the other hand were social workers from a school of social work, whose professional knowledge focused more on legislation, service systems and policy issues (Lehtinen 1986; Satka 1995). The different views on the role of health social work caused occasional clashes, but also created opportunities for mutual learning and productive dialogue.

Today, the question is sometimes raised as to whether health social workers need more knowledge on health issues than that which social work education currently provides. In the early days, knowledge on illness and nursing was evidently essential, and was a prerequisite for successfully collaborating with the medical profession (Åberg 1942; cf. Healy 2014, 38). Later, a break with the nursing identity was needed, to allow a more social perspective. Now today, once again, reasonable competence in the medical field is considered indispensable special knowledge for social workers working in health care (Ma 1997; Metteri 2014; Morén et al. 2014).

As well as extensive knowledge in many different areas, social work assessments and interventions also require solid relational skills. A recent study of complaints filed by patients in a Finnish hospital (Palomäki & Vanhala 2016) showed that the most common complaint was that of not having been heard and believed by medical staff in general. In health social work, relational skills have since the beginning been considered essential knowledge for trying to help patients adjust to a new life situation. In the 1940s and 1950s, Finnish health social workers studying in the US brought the social casework method to Finland (Toikko 2005, 160–165), and good communication skills still form the basis for social work practice.

As mentioned before, whether aware of it or not, social workers often use theoretical assumptions in their work, and they apply theory eclectically (Payne 2005, 30–32) or multi-theoretically (Forte 2014, 192–194). In later chapters, I will discuss some theories used in social work practice more in depth. In addition to these, other theories and concepts that have influenced health social work are, for example, social constructivist thinking, Bronfenbrenner's (1979) ecological systems theory, social support, risk and protective factors, resilience, attachment, and coping (Forinder & Olsson 2014); Gullacksen (2014) emphasises life adjustment in connection with chronic illness or disability as a process. In Finland, health social work has also been strongly influenced by concepts used in rehabilitation practice, such as social learning, life control, life management, empowerment (Järvikoski & Härkäpää 2004) and the biopsychosocial framework (Talo & Hämäläinen 1997).

Although social workers generally have been found to use research to a very limited extent (Trevithick 2008), Finnish health social workers show interest in research and want more collaboration with universities (Sub-study I). This might be due to the experienced need to strengthen their professional identity and knowledge base in a multidisciplinary environment. Health social workers often work quite autonomously (cf. Heinonen & Metteri 2005b) without much support from managers and social worker colleagues at the workplace; they draw more from supervision and in-service training. (Sub-study I.) This may increase their perceived need for research. The rapid development of electronic technology has meant a huge step forward in social workers' access to various kinds of knowledge in the form of guides, scientific literature and so on. Consultation with colleagues has also become easier.

The requirements for 'evidence-based practice' in health social work have not been strong in Finland compared to, for example, Sweden (Heiwe et al. 2013; Udo et al. 2018). One reason for this might be the high academic education of Finnish social workers, who assumingly are able to acquire the research-based knowledge they need with no external demands (cf. Hübner 2016). Another reason may have to do with how evidence-based practice is defined. In Finland, the discussions related to knowledge seem to be more about social work expertise (cf. Juvonen et al. 2018), in which knowledge is seen as multidimensional and consisting of, for example, contextual and client knowledge, relational and communication skills, a commitment to working with the client, reflective skills, and interprofessional skills. Social workers' critical reflection and research-mindedness are emphasised. (Pohjola 2007; Yliruka & Karvinen-Niinikoski 2013.)

2.4 Health paradigms and social work

In addition to the theories and concepts social workers themselves choose to use, their practice is influenced by the health paradigm(s) that prevail in the work setting. Rachelle Ashcroft (2011) maintains that social workers need to recognise prevailing health paradigms and critically assess the role they are given under different paradigms in order to decide whether they want to accept the role or whether they want to try to expand it in directions that better serve their patients. This section briefly reviews five health paradigms in terms of their influence on social work practice. These are the biomedical, the biopsychosocial, the social determinants of health, the salutogenetic and the holistic paradigms. Ashcroft (2011) suggests that the role of social work under different health paradigms be studied by using Malcolm Payne's (2005, 8–9) typology of social work views: the therapeutic (reflexive–therapeutic), the social order (individualist–reformist), and the transformational (socialist–collectivist) views.

The dominating biomedical health paradigm is influenced by objectivism. Health is seen as the absence of disease, pain and impairment; every disease is believed to have a biological cause, and when this cause is removed, the patient is considered well again. Diseases are seen as universal, and medicine as scientifically neutral, independent of culture and environment. (Healy 2014, 37.) According to Ashcroft (2011), social work practice shaped by the biomedical paradigm is situated between the therapeutic and the social order views; it focuses on improving the individual client's capacity to manage him/herself and on assisting the health institution to operate more effectively. Health social workers working in this kind of environment, as is the case for most of them, need to know about biomedical thinking in order to be able to collaborate with other health professions (Healy 2014, 38). New technological advances in biomedicine will probably further strengthen the biomedical health paradigm, and this challenges social workers to critically assess the implications for their work and their clients (Healy 2016).

The biopsychosocial paradigm, combining the biomedical and the social model of health, is particularly common in rehabilitative contexts (Talo & Hämäläinen 1997). In addition to the biological factors in patients' health, illness and recovery, it takes into account psychological and social factors (Engel 1977; Purola 1972), thus addressing both the micro and macro level. The paradigm is informed by both

objectivism and constructionism; social work under this paradigm mostly stresses individual intervention (the therapeutic view), although, depending on the context, it may also incorporate elements of the social order and transformational views (Ashcroft 2011). The biopsychosocial model has proven more useful for social work assessments than for intervention (cf. Chan, I.K., 1997). It has been criticised for not considering the dimensions of existence, personal meaning and spirituality (Ghaemi 2011). In social work, a spiritual dimension, referring to both spirituality and religion, and representing the 'personal search for meaning, purpose, connection, and morality' (Hutchison 2007, 8), has in fact been added to the framework (Maidment 2014). The purpose of the biopsychosocial model seems to be to advance a holistic approach. However, how the different domains can be integrated remains unclear.

Based on the biopsychosocial approach, WHO (2001) has created an international classification of functioning, disability and health (ICF), which includes physical and psychological functioning, activity and participation; it sees functioning as being influenced not only by the health condition but also by environmental and personal factors. The idea of the ICF is to be a framework for measuring health and disability at both individual and population levels. Implementations in social work are being developed and discussed (Barrow 2006). The ICF framework has been criticised for its weak conceptual basis, and improvements have been suggested (Ravenek et al. 2013; Solli & Da Silva 2012). The lack of a time dimension, necessary in studying recovery processes, has been pointed out (Matinvesi 2010).

The social determinants of health paradigm, informed by objectivism, constructionism and subjectivism (Ashcroft 2011), stresses the influence of social, environmental, political and economic forces on individual health (Marmot & Wilkinson 2006). The connection can be viewed from either a materialist perspective, which sees ill health as being caused by material living conditions, or from a social comparison perspective, which assumes that the experience of social inequity leads to worse health (Raphael 2006). Social work under this paradigm is strongly influenced by a transformational view of tackling social inequities, but it also works at the individual level from a therapeutic view (Ashcroft 2011).

A fourth theory that influences health social work is Aaron Antonovsky's (1996) salutogenesis theory (Forinder & Olsson 2014), which, utilising the concept of sense of coherence, studies what causes and maintains health. This concept has three components: comprehensibility, manageability and meaningfulness. Antonovsky

sees health as a continuum: the stronger a person's sense of coherence, the greater the likelihood that they move towards the health end of the continuum. Sense of coherence can be measured quantitatively (Haukkala et al. 2013; Rivera et al. 2012). This theory is compatible with strengths-based practice and ecological models of social work (Maidment 2014). In Finland, the salutogenesis theory is applied in some nursing homes as a paradigm to enhance the health of both residents and staff.

The holistic paradigm is more complex, as the use of the term holism is not consistent. The concept of holism in health, as used by Ashcroft (2011), is rooted in indigenous history and traditions: '[h]olism strives for a balance and harmony within the person; health is considered to be one part of a person's entire entity' (p. 620). Social work under the holistic paradigm sees clients as both a part and a whole, and encompasses all Payne's (2005) three views of social work: therapeutic, social order and transformation. As mentioned in Chapter 1, biography is seen as a holistic concept that contains structure, human agency and time (Miller 2000, 74-75).

Health social work often sees holism as embracing psychological and emotional factors and focusing on the social aspects of illness (Craig & Muskat 2013; Metteri 2014). Holism is often connected with the systems approach and with humanism, existentialism and spirituality (Payne 2005). The idea is to treat people as wholes, which is a central principle in social work. Some scholars argue that the physical environment (environmental social work) should also be included in the holistic view of the human being (Dominelli 2012; Matthies & Närhi 2014). The notion of holism has been criticised for its vagueness and lack of clarity; the social worker may be lost in the 'whole' and miss the focus of the work (Teater 2014, 33).

In Finland, holistic thinking in social and health care has been strongly related to the ideas of psychologist and philosopher Lauri Rauhala (1983). He identifies three forms of existence: consciousness (existence as experiencing), corporeality (existence as organic processes) and situationality (existence in relation to reality), which appears to resemble the biopsychosocial model. Another holistic model, defended by the Finnish psychiatrist Martti Siirala (1986), puts forward a more integrated view of the human being, seeing the mind and body as one entity, and physical symptoms of illness as communicating that ill-being is the burden of a sick society. Here, a person's illness is considered to be connected to their life history and life situation, reflecting and embodying the pathology of the surrounding society. Thus, the goal of care and

psychotherapy working together is, in a sense, to take the burden away from the sick person and turn it back over to society.

People often experience health care as fragmented and difficult to grasp (Huvinen et al. 2014). Holistic care attempts to bring the fragments together and consider other aspects of a patient's situation in addition to the medical ones. This is often done by bringing different professionals together into multidisciplinary teams to work on cases. This work can differ in quality and intensity. Multidisciplinary collaboration implies an additive view of wholeness, in which different professionals, such as physicians, social workers, physical therapists, occupational therapists, nurses and psychologists, autonomously make their assessments of a patient's situation, then coordinate their work and agree on the division of tasks. (Isoherranen 2012, 21–24.)

In interdisciplinary teams in turn, professionals of different disciplines collaborate in setting goals and working together, whereas in trans/crossdisciplinary teams, the professionals transcend disciplinary boundaries and integrate methodology and knowledge. One opinion is that the more intense the collaboration between professions, the more likely it is that an integrated view of a client's situation will be achieved. (Isoherranen 2012, 23–24.) On the other hand, one could argue that in transdisciplinary teams, the benefit of different professions and disciplines working together may be lost, and that the team work may be too dependent on the individual members. The idea of patients as partners in collaborative care has become stronger (Holman & Lorig 2000); the role of the social workers then becomes one of supporting patients in asserting their views.

The Swedish scholar Gunborg Blomdahl Frej (1988) maintains that the comprehensive view of care, as expressed in laws and guidelines, is cumulative and atomistic and primarily serves the carers rather than the patients. As a way of looking at wholeness from the patients' point of view, she proposes an existential relationistic approach based on Martin Buber's (1937) thinking. In her study of patients with a serious chronic illness, she found that 'human wholeness is created and recreated in close reciprocal relations' (Blomdahl Frej 1988, Abstract). Care as such cannot provide wholeness – the work should be based on the patient's own view of wholeness. This can only be done in a relationship and through dialogue with the patient. In an additive, that is, quantitative, view of wholeness, there is nothing more to a whole than its parts, whereas, in a qualitative view, a whole is more than the sum of its parts. When a person acts, it is the whole person, not just an organ or a part of an organ, that acts,

and a person's reasons and motives can be understood only by knowing their life story (cf. Solli & Da Silva 2012). This idea touches on the biographical aspect of human life and supports the notion of the biographical perspective being holistic.

The compatibility of these five health paradigms with the biographical perspective will be discussed in Chapter 6.

3 Research problem and methodology

3.1 Research problem

The research problem for this summary article builds on the results of six sub-studies and additional literature. Figure 1 illustrates the development of my research interest over the years.

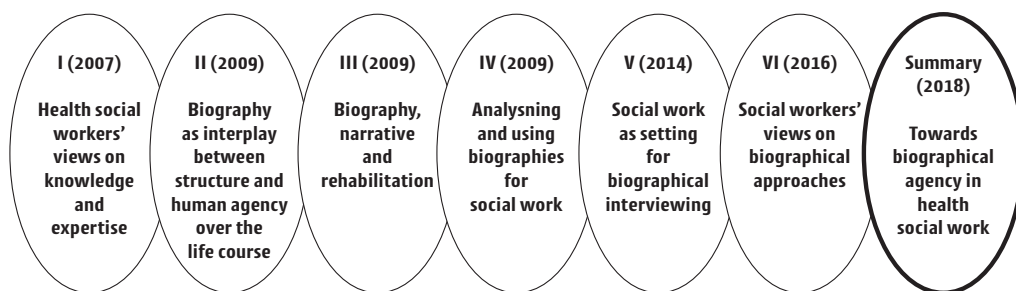


Figure 1 Development of research interest through sub-studies to summary.

My research process began with an interest in health social workers' views on knowledge and expertise in general (Sub-study I) and continued by exploring the biographical concepts and methods that might be relevant for social work practice (Sub-studies II–VI). This summary article ties together the threads of the sub-studies and takes biographical thinking a step further by studying what biographically informed social work practice might specifically imply in health care settings, and whether it can be applied to general social work practice theory. The research questions for the summary article are as follows:

1. *What might applying the biographical perspective in health social work practice imply?*
2. *Is a biographical perspective compatible with social work practice theory?*

Here, I distinguish between perspective and approach. By perspective I mean what Spearman (2005) refers to as...

... a particular way to view or understand part of the social and human world. It includes the concepts and theories that share the view and assumptions

of the perspective. In social work, a perspective guides and shapes the assessment process. It establishes a framework for assessment. (p. 46.)

An approach, on the other hand, refers to the actual intervention performed (cf. Teater 2014, 3). In one of my sub-studies (VI), I identified two levels of biographical approach: biographical methods and techniques, and a more general holistic framework, which I called 'biographical lenses'. In terms of perspectives and approaches, the biographical lenses can be seen as a perspective (a lens). The main biographical approach discussed in my research is the biographical (narrative) interview.

Finally, I understand social work practice theory as a theory for professional practice, which refers to formal theories intended to guide and explain social work practices (cf. Healy 2014, 111; Payne 2005, 4–5) as opposed to implicit theory, which refers to 'practice wisdom' (cf. Coulshed & Orme 2006, 14).

3.2 Overview of six sub-studies

The thesis builds on three empirical (I, V, VI) and three conceptual sub-studies (II, III, IV). The three empirical sub-studies were published as independent articles with separate research questions, data and methodology, which reported the analyses of empirical data. This summary article aims to theorise the themes discussed in the sub-studies without further analysing the empirical data. The three conceptual sub-studies are part of the one whole and therefore perhaps more coherent in nature. The research theme of the six sub-studies forms a logical whole, exploring issues of knowledge in health social work and the use of biographical approaches in social work practice from different angles. In this summary report, the sub-studies are connected to each other by an interest in defining biographically informed social work practice in health social work. Table 1 in the Appendix presents a brief overview of the six sub-studies.

The first sub-study (I), *Knowledge and Social Work in Health Care – the Case of Finland*, explored how health social workers acquire and maintain professional expertise, how they perceive knowledge and research, and whether they differ in this respect from social workers working in municipal social services. It used a mixed methods approach,

and complemented survey data with focus group interview data. Jennifer C. Greene and colleagues (2010) maintain that, in social work, complex social phenomena are often better studied using a mixed methods approach, and argue that this applies to assumptions about the social world in the philosophy of science as well as to research design, data collection and data analysis. Using qualitative as well as quantitative methods in the same study can provide knowledge about both micro and macro level phenomena. The methodological purposes for mixing methods can be triangulation, for example, or as in this case, complementarity.

The survey data used in this sub-study were drawn from a larger national survey conducted among Finnish social workers by Karvinen-Niinikoski and colleagues (2005) in the autumn of 2003. The purpose of the research project *Konstikas sosiaalityö* (The tricky social work) was to study professional practices in social work as well as the prospects and structures of the development of social work expertise. I participated in the research group that planned the survey, prepared the questionnaire and analysed the data. The questionnaire was sent out to a total of 1582 social workers, all members of the largest trade union for social workers in Finland. The response rate was 45.3% (N = 716). The final data were weighed accounting for language and consisted of answers from 583 social workers. Attrition analysis showed that the distribution of some main background variables of the respondents corresponded well with those of the whole sample, so, despite the rather low response rate, the researchers considered it possible to draw conclusions regarding the state of social work in Finland on the basis of these data.

The questionnaire contained a large amount of questions. For my own study, I used answers dealing specifically with knowledge and research, making comparisons between social workers employed in health care (N = 110) and social workers employed in municipal social services (N = 295), which is the major employer of social workers in Finland. SPSS was used as statistical software. The survey data were analysed using frequencies and cross tabulation, and, where possible, significance was tested using the Chi-square test for independence. An open question regarding the respondents' views of the future was analysed using SWOT analysis. In addition, a qualitative focus group interview of seven health social workers was conducted in a university hospital. The interview data were analysed using qualitative content analysis, and the results were used for reflection on the survey results. The results of the study showed some significant differences between social workers employed in health care and social

workers working in municipal social services. The main differences involved education, work experience, working conditions and professional support.

As regards the ethical aspects of collecting and handling the empirical data, the survey research data were analysed and presented in such a way that no individual respondent could be identified. With qualitative data, ethical issues regarding data collection and analysis are often more complex. The participants of the focus group evidently knew what the other participants in the group had said, and they were asked not to reveal this outside of the group. The group itself can possibly be identified, but individual members of the group are hardly identifiable because of the turnover of employees in the unit. The interview results were reported in a general way. It has to be noted that the survey data of Sub-study I were collected more than a decade ago, and Finnish health social workers' attitudes towards knowledge may have changed somewhat since then. All social workers with 'social nurse' education have retired by now. My guess is that, with more workers now holding a master's degree, research knowledge may be more easily acquired. On the other hand, the professional identity of the health social worker may previously have been stronger.

Empirical Sub-study V, entitled *A Social Work Perspective on the Biographical Research Interview with Natalia* (2014), was conducted on the basis of a presentation at a workshop of the Research Network RN3 of the European Sociology Association, held in Łódź, Poland in September 2012. In this workshop, four sociologists and myself each presented our analysis of a lengthy transcribed biographical research interview, which had been conducted by Polish biographical researcher Agnieszka Golczyńska-Grondas (2014a) as part of her research project. Our biography case analyses were later published in a scientific journal (ibid.; Riemann 2014; Urbańska 2014; Waniek 2014; Sub-study V). The research interviewee in this study was a woman who had spent several years of her adolescence in residential care. She had responded to an invitation letter sent out by the university to former residents of children's homes and volunteered to tell her story to the researcher. The interview was 45 pages long (printed in Golczyńska-Grondas 2014b). Since my analytical task was to bring a social work perspective into the sociological workshop, I decided to use a social work practice approach which is fairly commonly used by social workers in Finland, namely the strengths perspective (Saleebey 2013). I analysed the content of the interview, looking for strengths and resources that, in a practice situation, could have been discussed with the respondent. From a social work

practice viewpoint, I found major differences in this research interview compared with the research situation. The strengths-based practice approach worked quite well in the analysis despite the fact that, in social work practice, the interview and the analysis would have been conducted through much more dialogue with the narrator. In research, the researcher generally interprets the interview; in social work, the client's own interpretation of their life and life story forms an essential part of the assessment. No computer software was used for this analysis.

The research data of empirical Sub-study VI, entitled *Does past life matter? Social workers' views on biographical approaches* (2016), consisted of 16 final essays written by social work practitioners attending a course on the use of biographical approaches in social work, conducted in 2005–2006 as part of the EU research project INVITE. The instructions for the final essay asked the participants to assess what they had gained from the course and whether and how it had possibly changed their way of working with clients. The number of pages analysed was 103 (3–17 per person). The respondents represented different fields of social work: psychiatry, addiction treatment, rehabilitation, long-term residential care for people with brain injury, the elderly, pre-adoption counselling and vocational college. The texts were analysed using qualitative content analysis. No computer software was used.

The essays analysed for the study were handled in a way that ensured the anonymity of the respondents to the greatest extent possible. In this case, the risk of identification of individual respondents cannot be completely avoided. Since the fields in which the respondents were working were considered important, they could not be excluded when presenting the results. When there is only one respondent working in a particular field, identification is always possible in principle. However, the essays were not about highly sensitive issues or about identifiable clients; they were about the respondents' professional views on the use of biographical approaches, which are not essentially secret.

The results of this study were simple and clear: the main benefits of biographical approaches in social work practice were seen on the one hand as providing a space for clients to reflect on their lives, and on the other hand as providing a space for social workers to listen to their clients' life stories. Listening carefully was also seen as ensuring a better understanding of clients' life situations. The challenges posed by biographical approaches were the client/worker relationship, ethical issues and the prerequisites for biographical-narrative interviewing.

Sub-studies II–IV, that is, *Social Constraints and the Free Will – Life Course and Vocational Career* (2009) (II), *Biography, Narrative and Rehabilitation* (2009) (III), and *Social Work Case Analysis of Biographical Processes* (2009) (IV), were produced within the educational curriculum designed in the EU research project INVITE – New Ways of Biographical Counselling in Vocational Rehabilitative Training, conducted under the Leonardo da Vinci programme in the years 2003–2006 (European Studies on Inequalities and Social Cohesion 1-2/2008 and 3-4/2008; modules originally published online in 2006)⁶. These sub-studies were mainly based on the literature and thus conceptual. They introduce some basic biographical concepts and present and discuss biographical approaches relevant for vocational rehabilitation and social work practice. In the co-authored Sub-study IV, my input is a theoretical discussion on the analysis of biographical-narrative interviews and on the use of biographical approaches in social work practice.

Theoretical–conceptual research answers the question of how a theory, model or framework that describes or explains a certain part of the real world can be derived (Järvinen & Järvinen 2011, 15). My question is: what kind of framework describes the relevance and implementation of the biographical perspective and biographical approaches in health social work practice? In accordance with S. Gregor (2002; 2006), Pentti Järvinen and Annikki Järvinen (2011) distinguish different types of theory according to the following criteria: the questions that the theory type answers, its categories, and the research methods that can be used to create the theory type in question. In my research, I create a framework for analysis and description, which answers the question ‘What is?’. Plain descriptive frameworks name the dimensions or characteristics of a phenomenon, and slightly more complex frameworks classify the modes of and interrelations between the features or characteristics of a phenomenon. Methods suitable for creating these frameworks are the analysis of existing evidence or data, philosophic or historic research, and empirical observation. (Järvinen & Järvinen 2011, 16–17.) In conceptualising the biographical perspective for health social work practice, I analyse existing evidence, that is, the literature, and use my own empirical observations.

6 The participating universities of the EU research project, INVITE were those of Magdeburg in Germany, Łódź in Poland, Bangor in the Wales/UK and Helsinki in Finland. Practice institutions in these countries and in Austria and Italy also participated. As well as in English, the modules have been published in German, Polish and partly in Swedish.

3.3 From sub-studies to summary article

Drawing on the sub-studies, this summary article continues the conceptual analysis of the possible benefits of a biographical perspective in social work practice, focusing specifically on the health care setting. The fact that my thesis research has continued for over a decade means that my thinking on these issues is likely to have deepened and partly even changed during this time. However, in retrospect, the sub-studies imply a process which, in spite of its twists and turns, seems necessary: from studying health social workers' attitudes to knowledge in general (I) and defining certain basic concepts in biographical sociology (II, III), I progressed to exploring how biographical approaches can be implemented in social work practice (IV, V) and to analysing how practitioners view biographical approaches (VI).

The main concepts defined in the sub-studies, that is, life course, social constraints, free will, biography, narrative, biographical work, and biographical trajectory are all relevant for the summary article. Strangely enough, the sub-studies hardly mention the concept of agency; instead, the idea of an acting subject is hinted at in terms such as 'free will' and 'mastery'. The interplay between individual and society is analysed using Bourdieu's (1980, 43) habitus theory (Sub-study II), which does not imply a very active subject. Hardly any distinction is made between the concepts of narrative and biography, a distinction I now find essential, even though these concepts overlap in many ways. Interviewing in biographical and narrative research, as discussed in the sub-studies, is relevant for the research problem of my summary article, as are the examples of how biographies and narratives can be used in social work practice. The last sub-study, which explores social workers' views on biographical approaches, presents the opinion of those immediately concerned with the application and is highly relevant for the research problem of my summary article.

The ideas and concepts presented in the sub-studies together create a 'biographical perspective' for social work practice, which, in the summary article, I take further by suggesting a definition of biographically informed health social work practice. The ideas emerging from the rather disparate collection of sub-studies had to be tied together with a robust tool – a tool that I found in the comprehensive concept of biographical agency (Heinz 2009b; Hitlin & Elder 2007). This concept seemed suitable for linking together different aspects of biographical ideas for health social work practice.

The literature studies for this summary article aimed to obtain a better overview of biographical sociology and of biographical approaches already in use in social work practice. In my initial search for relevant scientific articles, I was surprised to find so little on the use of biographical approaches in social work practice. Biographical research on patient groups existed, but I failed to find much on how to work with clients using biographical approaches. As to the key term of biographical agency, except for Heinz 2009a, I found only one article (Al-Rebholz 2014) that used this concept. However, agency within the life course is more widely discussed.

This whole research process has been a true learning adventure; each sub-study has brought new knowledge regarding biographical thinking and new ideas for professional practice. The biographical concepts and methods that I initially learnt largely from the German researchers of the INVITE project have most likely left their mark on my understanding of biographical sociology.

4 Biography in research

4.1 The concept of biography

My theoretical framework is in biographical research. In this chapter, I discuss some concepts, ideas and methods essential for my research.

The concepts of biography, narrative and life course are related but different. The classic definition of biography (from the Greek 'bios' = life and 'graphein' = write) is an account of a person's life, told in writing by the person him/herself (autobiography) or by another person. Today, biographies can also be related orally (Roberts 2002, 176). Another definition of biography is 'a person's unique history of thinking, feeling and acting' (Macionis & Plummer 2012, 211) tied to a specific historical moment and a specific generation that has lived through specific world changes; biography is defined as dealing with the phases, sequences and turning points in a person's life, as remembered and told later (ibid., 824). Biography has also been defined as constituting the very force that creates inner coherence and meaning in a person's life (Svenbro 2005, 12).

Further definitions describe biography as a type of 'self-reflection and self-description that also uses temporal distinctions and thus can structure the life-time of individuals and define temporally differing engagements and participation in institutions' (Fischer-Rosenthal 2000, 115) or 'the subjective processing of a person's life' (Roer 2009, 187). The interplay between individual and history, inner and outer worlds, self and other, and 'the relationship between the particular and the general, uniqueness and commonality' (Merrill & West 2009, 1–2) are considered central issues. 'Biographical' mostly implies developing a biographical argument, that is, identifying the biographical development of action patterns or identity structures and locating particular experiences in the context of a person's entire life. Biographical issues can also be studied without developing a biographical argument; for example, using standardised research instruments. (Zinn 2010, par. 28.)

A major distinction in much biographical research is that between life as told and life as lived. Gabriele Rosenthal (2004) distinguishes between biographical data, life history (lived life as experienced) and life story (life as told). Biographical data are seen as free of interpretation by the narrator; they can be, for example, date of birth, number of siblings, educational data, working career, establishment of family, change of residence and illness data. The life history comprises life events as experienced when they happened, and the life story expresses how the person views their life experiences and relates them to others in the present time.

Not all biographical scholars find it necessary to distinguish between different aspects of biography. Fritz Schütze (2009a, 166), for example, does not see the need to distinguish between socio-biographical processes and the narrative renderings of these processes. He uses the term 'life history' or 'biography' to refer to both. He argues that life course processes are very much shaped by how personal life experiences are ordered in autobiographical narration. Other scholars define life history as a life story validated by information from external sources, such as official records, letters or diaries, which aim to put the life story into a wider social and historical context (Goodson 1995, 97). Life stories can be of different kinds: they can be comprehensive, about a person's life in depth; they can be topical, about one particular issue in a person's life, or they can be edited by the researcher (Nilsen 2008, 83).

The concept of biographical disruption has been used in connection with chronic illness in order to describe what happens when a person's taken-for-granted assumptions and behaviours, as well as explanatory systems, are disrupted (Bury 1982). However, this concept is not without problems. Simon J. Williams (2000) suggests that attention should be paid to meaning, context, timing, purpose, commitment and expectations. What may be a disruptive experience to previously healthy people may be part of normal life for people who are already living a life with health or other problems, in which case the onset of a chronic illness is more a biographical confirmation or reinforcement (*ibid.*, 50).

Chronic illness may even be experienced as a relief in a stressful life situation. I noticed this in my own study of dialysis patients (Björkenheim 1992), when a woman expressed relief at her current life on dialysis after having been under great stress both at work and at home before the onset of the illness. With chronic illness, there is seldom only one single disruption; often the condition declines and is later followed by new complications (Jeppsson Grassman et al. 2012). The relationship between social, psychological and biological factors in health and illness has been discussed in medicine, especially in psychosomatics (Karlsson 2008).

Biographies are often presented in a narrative form, but not all narratives are biographical (Riemann 2003, par. 16). The concept of narrative (*cf.* Sub-study III) is much discussed in sociology. Hyvärinen (2016), for example, distinguishes between three different orientations, which all seem relevant for social work: the analysis of narrative texts, storytelling sociology, and the analysis of narrative realities. Riessman (2008) in turn sees the concept of narrative as interchangeable with that of story,

defined as having a beginning, a middle, an end and a plot. Narrative has a meaning-making function, and storytelling can be used to make sense of events as well as to construct identity. As well as in (auto)biographies, narratives can be present in, for example, archival documents, and social service and health records. (Ibid., 4–10.) In social work practice, where biographical facts and experiences are often important per se, it seems relevant to distinguish between narrative (story) and biography (both life as told and life as lived).

Another concept often used in biographical research is life course (Sub-study II), which is ‘a configuration of social and individual components which develops over time’ (Heinz et al. 2009, 16) and

a – historically variable – socio-culturally and politically constructed institution that produces societal continuity and social integration through structurally embedded sequences of age-related status configurations which refer to individuals’ societal participations and orient (but do not determine) biographical action
(Wingens & Reiter 2011, 189).

The life course paradigm deals with generational differences; the social meaning of age; timing and sequencing of life events, and the scheduling of trajectories; the interlinking of lives; and human agency in life planning (Lopata & Levy 2003, 4-5).

How does the concept of life course differ from the concept of biography? Life course, referring to life as a whole with its life stages, describes human life on a general level and refers to the ‘outside’, whereas the concept of biography describes unique human lives, experiences, thoughts, and actions as conscious experiences from the ‘inside’ (cf. Roberts 2015, 13). Life span in turn is a psychological concept that refers to human development (Baltes et al. 2006). All these concepts are relevant for understanding human life in social work. In the following section, I discuss the development of biographical sociology and the distinction between biographical sociology, life course sociology and life span psychology.

4.2 Biographical sociology

Having developed along different research traditions in different countries (Apitzsch & Inowlocki 2000), biographical sociology is today a recognised field of sociology with its own theoretical, methodological and epistemological developments (O'Neill et al. 2015). The biographical turn in the social sciences implies a subjective or cultural turn in which the personal and social meanings of people's actions are considered more important (Chamberlayne et al. 2000). The sociological study of individual lives, starting with W.I. Thomas' and F. Znaniecki's comprehensive study of Polish migrants in Poland and Chicago, published in 1918–1920, marked a new way of conducting research using subjective data. C.W. Mills (1959, cited in Nilsen 2008, 86), influenced by American pragmatism, argued that the proper subject for sociological study should be the intersection between history and biography, and that sociology should study the actions, thoughts and feelings of individuals, contextualising them in history. In the 1970s, life course research – studying life course events in the light of cohorts and historical periods – emerged, and oral history – interviewing people about their recollections of the past – was developed for use in the history science. (Nilsen 2008.)

There is no one singular biographical approach or biographical theory. Biographical research, drawing on different materials and interpretive approaches for studying individuals' daily life experiences and their past and future perspectives, can be informed by different theoretical stances (Roberts 2015). At the beginning of the last century, the epistemological perspective was a realist one, arguing that biographical material could provide access to some form of 'truth' about life events. In the 1980s, the hermeneutical approaches in social science and linguistics drew attention to the language and narrative structure of biographical accounts; the 'told life' became more interesting than the 'lived life'. This linguistic turn implied a constructionist standpoint, which sees reality as being constructed through interaction between people. (Nilsen 2008.)

In discussing the quantitative–qualitative, the positivist–interpretive, and the realist–constructionist divides in biographical research, Ann Nilsen (2008) stresses the importance of both content and form. In her view, life experiences cannot be recalled without a notion of reality beyond language. However, the narrative structure of a biographical account can add a great deal to the understanding of the

context of an individual life. These divides created by the epistemological debates in biographical research can, according to some, be overcome with the notion of agency (Chamberlayne et al. 2000).

In Germany, biographical research is generally based on the social constructionist research approach according to Berger and Luckmann (Rosenthal 2015). Symbolic interactionism and the ethnography of communication are important in Fritz Schütze's frame of ethnographic interaction analysis (Kaźmierska 2014, 311). In some francophone countries in particular, researchers (Bertaux & Delcroix 2000; Turk & Mrozowicki 2014) have used (critical) realist approaches. Finnish biographical research in the 1980s saw a strong realist wave (Roos 1985), which later turned into a strong narrative wave (Lillrank 2003; Nousiainen 2004; Vilkkko 1994). The (critical) realist trend may now be re-emerging (Pekkarinen 2014) alongside the narrative one.

A strand close to biographical research is life course research, which studies macro-level phenomena with the assumption that life history has an impact on later life outcomes (Mayer 2009). Some of the basic concepts in life course research are also used in biographical research. Transition refers to a distinct change in roles and statuses; trajectory is defined as 'a long-term pattern of stability and change, which usually involves multiple transitions' (Hutchison 2011, 12; cf. Sub-study III). A life event in turn is 'a significant occurrence involving a relatively abrupt change that may produce serious and long lasting effects' (Hutchison 2011, 12). Finally, a turning point marks a major change in the life course trajectory and is produced by a life event or a transition (ibid.). Being diagnosed with a chronic illness is often experienced as a life event which may become a turning point, changing a person's life trajectory. Having to adapt to this type of major life change can be regarded as handling a life transition (Heinz 2009a). The concept of trajectory has also been used in connection with serious illness and dying (cf. Sub-study III).

Life course analysis is important for social policies that aim for preventive intervention (Mayer 2009). Certain research on the social determinants of health is done from a life course perspective (Marmot & Wilkinson 2006). Studies have shown that psychological dispositions are more often modified by life course events than the other way around (Mayer 2009). However, it has also been demonstrated (Laub & Sampson 2003, cited in Mayer 2009, 418) that, in certain cases, such as those of juvenile offenders, earlier trajectories can be modified in adulthood by both institutional and

human agency factors. This, of course, is good news for professionals who work to improve the life of people with a disadvantaged past.

Life course sociology has much in common with life span psychology (Diewald & Mayer 2009). However, in terms of variation in life course patterns for different birth cohorts and between countries, gender and social classes, life course sociology primarily studies individual life courses as regularities produced by institutions and structural forces (ibid., 6). Life span psychology in turn studies age-related regularities, interindividual differences and intraindividual plasticity in human development, explaining development with biological, psychological, social, and environmental factors and mechanisms (Baltes et al. 2006, 570). Both life course sociology and life span psychology generally use quantitative approaches, whereas biographical sociology mostly uses qualitative approaches.

Knowledge produced by life course sociology and life span psychology can be very useful to social workers, who need to understand human development as well as the impact of institutional and social structural forces in shaping human lives (cf. Pohjola 1994; Wilson et al. 2011, 126). Life course research can provide an important framework for understanding the social and historical contexts in which people have lived their lives, referring to this as the 'social time table' (Elder 2009, 93). Biographical sociology, on the other hand, sees the individual as an actor who aims to make their way through the social and historical world. The focus is on individuals' unique lives and the meaning they give to their lives. Eva Jeppsson Grassman and colleagues' (2012) research, based to a large extent on qualitative interviews with aged and/or disabled people, aim to combine a life course approach with a biographical approach.

4.3 Biographical interviewing and analysis

The approaches used in biographical research are generally qualitative micro-sociological. Biographical methods have usually referred to forms of narrative, life history/story, oral history, biographical interpretive methods, storytelling, auto/biography, auto/ethnography and reminiscence. Recently, biographical interviewing and analysis have taken more varied forms, allowing, for example, structured

questioning and topic-centredness, and using digital technologies. In addition to interviews and writings collected explicitly for research purposes, biographical research data may include older texts and documents, produced independently of the research. (Bornat 2008; Roberts 2015.)

Biographical methods provide 'a tool for reconnecting welfare systems with lived experience and processes of social change' (Chamberlayne 2004, 19). Biographical interviewing is the most common biographical method in research. Joanna Bornat (2008) compared three biographical interview methods: the biographical interpretive method (Rosenthal 2004; Wengraf 2000), narrative analysis (Riessman 2008) and the oral history method (Bornat 2004). All three methods emphasise the biographical interview as a social interaction and stress subjectivity, that is, the interviewee's expressed feelings and meanings (Bornat 2008, 349). They all see the structuring of the dialogue as methodologically relevant and the context as significant. The main differences relate to interrogation, memory and interpretation.

In the biographical interpretive method, the biographical-narrative interview, as developed from the interview method described by Schütze (2009b), starts with an initial question intended to generate the main narration, with no interruptions by the interviewer. The initial question is formulated in a way that makes the person narrate their involvement in relevant events and experiences, not merely give an account of facts and events. After the main narration, narrative questions are asked around the topics mentioned and around other themes of interest for the research topic. When the narrating is finished, descriptive and argumentative questions can be asked. In a biographical-narrative interview, the narrator structures the story in a way that they find meaningful; the memory process is supported, and fragments are chained together into a whole picture (Rosenthal 2003).

For the interpretation of biographical interviews, Rosenthal (2004) developed a biographical case reconstruction method based on biographical data, life experiences and life story. First, biographical data, retrieved not only by interviewing the respondent but also validated from other sources, such as archive material, official files, medical records and interviews with family members, are arranged in chronological order. Independently of the meaning conveyed in the narrator's life story, the researcher makes several possible interpretations of biographical data and reconstructs the life history. The life story is reconstructed separately, based on text and thematic

field analysis. Finally, the biography is reconstructed through a comparison between the life history and the life story, between past and present perspectives.

Biographical scholars maintain that, to understand the individual areas or phases of a person's life, the structure – the 'gestalt' – of the entire life story must be considered. The narrative gestalt of a biography is expressed by the way in which the narrator orders the telling of their life experiences. In his 'socio-linguistic process analysis'⁷, Schütze (2009a, 175–191) looks for the overall gestalt in a biography by studying the preamble (introduction) and the coda (end) and by using four biographical process structures: the biographical action scheme, institutional expectation pattern, creative metamorphosis and the trajectory of suffering. The biographical action schemes, verbalising the intentional principle, are expressed in the text as formulated intentions, conveyed thoughts and plans, and they assess and evaluate the means to carry out the plans. The institutional expectation patterns express the normative principle, and the creative metamorphoses of biographical identity express the start of a new major inner biographical development.

A trajectory of suffering expresses a lack of capacity to actively shape one's life and is a reaction to outer events that have negatively changed the person's life. A trajectory process has six stages: a trajectory potential is built up; the person starts to think more in terms of whether something is possible rather than of when they will do it; everyday life becomes more uncertain and unstable; self-orientation breaks down; the person tries to cognitively come to terms with the trajectory; and, finally, the person works practically on the trajectory, trying to escape from it either by reorganising their life situation or by working on eliminating the trajectory potential. (Riemann & Schütze 1991.) This concept has been suggested for analysing clients' problem situations in social work.

Narrative analysis differs from the biographical interpretive method in that the researcher is mainly interested in the story told and its meaning-making function, and seldom in whether the events related really happened. The focus is usually on particular sequences of action, on the choice of language and narrative style and on audience/reader response. (Riessman 2008, 10–13.) Two methods of analysis have been distinguished: the paradigmatic-type analysis, in which themes are analysed across narrative data; and the narrative-type analysis, in which explanatory stories are produced from narrative and/or non-narrative data (Polkinghorne 1995).

7 Term used by Gerhard Riemann at a meeting in Nürnberg on September 18th, 2015.

In oral history, interviewing is semi-structured with more dialogue (Bornat 2008). Memory takes a more active role; it plays a part in the present. Oral historians use life-history methods as an emancipatory tool and have created the concept of empowerment for welfare practices (Chamberlayne et al. 2000, 2). As a consequence, many of them seek to maintain an interpretive distance and to stress individuals' own interpretations of past experiences, to avoid over-interpreting life stories and distancing the interviewees from their own words. Oral history draws widely on sociology and history. Narrative analysis is influenced by sociolinguistics, whereas in the biographical interpretive method, a common framework seems to be psychoanalysis. (Bornat 2008.)

Many biographical researchers have determined that biographical research interviewing often has a therapeutic side effect (Betts et al. 2009, 26–31; Golczyńska-Grondas & Grondas 2013; Merrill & West 2009, 175; Rickard 2004; Rosenthal 2003; Schütze 2009a, 159–160). Rosenthal (2003), a biographical researcher and family therapist, has described how traumatised narrators may heal during biographical storytelling. By telling and reflecting on their life story and having it validated by the interviewer in the role of an active listener, the interviewee's self-understanding increases. The narrator interprets their story without much input from the interviewer. This implies that biographical-narrative interviewing is indeed an intervention, and not only a method of data collection. This has implications for research, in which intervention is not intended or contracted nor the researcher prepared to deal with narrators' traumatic memories (Golczyńska-Grondas & Grondas 2013).

4.4 Biographical agency

In this section, I discuss my main concept, which is biographical agency; other important concepts are biographical work and biographical identity. The various sociological research traditions have diverging views on what constitutes human agency and how the individual and social levels relate to one another (Eteläpelto et al. 2013). Generally speaking, the relation between individual and social can vary from social determinism, which sees individuals as being completely defined by social circumstances, to extreme individualism, which in turn sees individuals as completely responsible for how their

life unfolds (Settersten, Jr. & Gannon 2009). Anthony Giddens's (1984) view is that the actions performed as a consequence of human agency are conscious and intentional, and that individuals have the capacity and power to act in accordance with their intentions, that is, the individual has the choice to act in different ways. Giddens's theory of structuration has been criticised for emphasising individual rational action without sufficiently considering the impact of the social context.

Margaret Archer (2000; 2003), taking a critical realist stance, maintains that individual and society should be understood as being temporally different and in interplay with each other, and she argues that human beings have not only social but also practical and embodied relations to the world. In cases of illness, the body is indeed significant. The importance of time for human agency has been strongly expressed by Mustafa Emirbayer and Ann Mische (1998) in their definition of agency as a process informed by the past and oriented towards the present and the future. In the present, individuals make judgments about how to act on the basis of their past experiences, imagining possible outcomes in the future and considering different aspects of the context, which may be either constraining or enabling. The individual and social levels are seen as analytically separate, and agency is considered to have both reproducing and transforming structures.

Based on semiotic sociology, human agency has been conceptualised (Jyrkämä 2008) as having six dimensions (modalities): knowing-how-to, being-able-to, wanting-to, having-to, having-the-possibility-to, and feeling-about. Knowing-how-to refers to the skills and knowledge an individual accrues over time, for example, knowing how to swim. In certain circumstances, a person may not be able to swim due to, for example, lack of physical or psychological capability. Wanting-to refers to motivation: does the person want to swim or not? Having-to refers to social, physical, moral or other possible constraints that oblige the person to swim; if, for instance, a boat has capsized swimming may be the only way out. Having-the-possibility-to refers to wider constraints and opportunities: swimming may not be possible due to, for example, strong current. Feeling-about, finally, refers to how an individual feels about and experiences swimming, and may be connected to whether or not they want to swim. These different modalities can help identify more specifically different aspects of agency in relation to social constraints and opportunities in different life situations; for example, living with depression (Romakkaniemi 2010), living in an old people's home (Jyrkämä 2007) or being young and living in the remote countryside (Vaattovaara 2015).

Another dimension of human agency is the autonomy–relationality dimension. Autonomy implies that people want to and are able to make individual decisions and choose to act in alternative ways according to their own will. However, a person’s capability to make autonomous decisions about their life may be restricted by illness and impairment. On the other hand, people are connected in different ways to other individuals, groups, networks, communities and social structures, in ways that have an impact on their agency. (Juvonen 2015, 39–43.) Agency is always a relational and dialogical process (Emirbayer & Mische 1998, 973-974).

The identity and life course research tradition approaches human agency from the perspective of how individuals construct their life course within the social circumstances under which they live. Social conditions and human action are seen as separate entities; social circumstances are seen as both providing opportunities and causing constraints for the individual. (Eteläpelto et al. 2013.) Life course researchers Steven Hitlin and Glen H. Elder, Jr. (2007) identify four overlapping types of agency according to the time dimension: existential, pragmatic, identity and life course agency.

Existential agency implies a general capacity for self-directed action and forms the base for the other three types of agency. Pragmatic agency implies the ability to act in the present moment in problematic situations when habits and routines break down. An example of this could be when a person is diagnosed with renal failure and suddenly has to change their daily routine and remember to take regular medication, adhere to dietary restrictions and undergo dialysis treatments. Pragmatic-agentic decisions are influenced by personality, biography and values.

Identity agency implies acting according to the social roles and identities the person is committed to, for example, the role of teacher, social worker, mother or customer. In exercising identity agency to perform current roles, individuals are guided by their past behaviour and experiences. This frees capacity for concentrating on other things while performing these roles. When family and professional roles change due to changes in daily life, the identity agency connected to these roles is no longer adequate. When new social roles and identities are taken on at school, at work and in the family, for example, identity agency is again called into play. (Hitlin & Elder 2007.)

Life course agency, the fourth type of agency mentioned by Hitlin and Elder (2007), refers to the ways in which individuals attempt to shape their lives in a long-term perspective within prevailing historical, social and biological conditions, and to their

ability to make choices at turning points. Life course agency connects the past and the future to the present and includes anticipating and reflecting on the consequences of actions in a time perspective (Heinz 2009a, 423). According to Hitlin and Elder (2007), life course agency contains not only action but also a 'self-reflective belief about one's capacity to achieve life course goals' (p. 182). Later, 'perceived life chances' was added to this concept of agency (Hitlin & Johnson 2015, 1431).

Hitlin's and Elder's (2007) conceptualisation of life course agency has been criticised (Vanhalakka-Ruoho 2014) for focusing too much on the individual's capabilities and capacities, self-efficacy and optimism, and for emphasising the cognitive and rational aspects of agency. Vanhalakka-Ruoho maintains that a life course approach should capture the interplay between the acting individual and the changing environments and structures. One problem seems to be that agency, and especially its interplay with structural constraints and opportunities, has been difficult to study empirically (cf. Hitlin & Johnson 2015).

In the literature, life course agency and biographical agency, for the most part, seem to be used interchangeably (Heinz 2009a, 422–423). I choose to use biographical agency (cf. Al-Rebholz 2014) because it emphasises the inside perspective. Walter R. Heinz (2009b) defines the concept of *biographical actor* as follows:

This concept integrates a person's life history and life perspective, her perceived options and situational circumstances. It constitutes a complex and constructive frame for life course decisions. Biographical action refers to the fact that individuals attempt to link their experiences to transitional decisions and that they interpret their options not only in respect to subjective utilities and social norms, but in terms of the legacy of their personal past. Biographical action is the central contribution of individuals in negotiating status passages with institutions and social networks, for example at exit and entry processes between old and new status configurations. (Heinz 2009b, 478–479.)

Heinz (2009b) studied human agency in life transitions and status passages relating to age and the life course, such as marriage, child birth and working career.

The concept of life transition might also be useful when studying turning points caused by serious health problems. Heinz refers to four dimensions that affect life transitions: institutional control, awareness context, interdependence and reversibility.

Classification of status passages according to these four dimensions may serve to identify the relation between institutional regulation and the individual's scope for biographical action, as well as to assess the individual's possibilities to arrange and negotiate the timing and duration of their new life phase.

In the adaptation process required in a major life change caused by serious chronic illness or severe impairment, the dimension of institutional control would refer to the extent of control institutions have over how people with a chronic illness live their daily lives and what they can plan for the future. Status passages can be more or less open to negotiation between biographical actors and institutional gatekeepers (Heinz 2009b). Chronically ill individuals may, for instance, have to negotiate with their school teacher or employer about special arrangements to enable them to continue studying or working; they may have to apply for social security and other financial resources and for rehabilitation benefits and services, which they may or may not be granted.

The awareness context dimension in a life transition is the extent to which a chronically ill person can make decisions regarding their own situation concerning matters such as school, work and social services. This is often determined by the knowledge they have of institutional regulations and the outcome of different pathways. The interdependence dimension in a life transition refers to pathways that are connected to each other and how dropping one social relationship causes turbulence in another; for instance, having to retire from work may affect family life. The reversibility dimension in turn refers to the possibility that a status passage may be reversed (Heinz 2009b). For the chronically ill this could mean the possibility of regaining functioning through rehabilitation or later medical treatment alleviating the social consequences of the illness. For example, a successful renal transplant ends the need for maintenance dialysis treatment and makes a person's daily life more normal again.

Human agency can be seen as existing in three modes: personal, proxy and collective agency (Bandura 2006, cited in Hutchison 2011, 27). Personal agency refers to an individual's intentional choice, combined with capability and power to carry through intentions; proxy agency refers to influencing others to act on one's behalf, for example, clients influencing social workers to act on their behalf; and collective agency refers to a group of people acting together. Social workers' personal agency has been discussed in different contexts (Marston & McDonald 2012); in my research, the focus is on the personal agency of clients.

Marja-Liisa Honkasalo (2008) introduces enduring as a mode of human agency, which is minimal and not always visible to others. This type of agency is particularly relevant in the context of living with uncertainty; for example, living with chronic illness or enduring chronic pain. The time perspective in enduring is open-ended. People who live in a state of uncertainty about their pain and illness often say that they live 'one day at a time' (Lillrank 1998). They may not be able to make active decisions about changing their lives, but they exert agency, merely by enduring. In health care, staff often perform minimal agency in the form of being present with very sick or dying people.

Honkasalo (2008) also mentions the concept of ethical agency as an aspect of enduring in a difficult life situation when there seems to be no alternative. As an example, she mentions women who endure taking care of their sick, alcoholic husbands without expecting any change in the situation and without knowing how long the situation will last. They merely feel responsible for the other person and cannot choose to do otherwise. Patienthood (Lämsä 2013), which refers to being an inpatient on a hospital ward, often implies a state of enduring, seldom allowing for much self-directed agency. Health social workers often meet people who face uncertainty and endure because of either their own or a family member's illness.

Shared agency in this context implies that human agency is shared between the client/family and a professional; they have shared goals and a common understanding of how to reach these goals (Järvikoski et al. 2013). In a study of depressive patients attending a mental health agency, the authors (Romakkaniemi & Järvikoski 2012) found that shared agency was important in three domains: in the emotional domain, shared agency implied being heard and building confidence; in the communicative domain, it implied sharing mutual information, finding words to describe chaos and reconstructing harmony; and in the supportive domain, shared agency implied receiving encouragement and support. The authors were surprised to find that shared agency was seldom used for setting life goals and planning for the future, even though the respondents seemed to expect this. Shared agency requires a trustful client/worker relationship and thus the concept has relevance for relationship-based work, which is important in biographically informed social work practice.

Biographical agency contains the idea that individuals are not only products of their past, but also biographical actors who, within certain frames, can change their future through active decisions and actions that take into account their past life, current situation and future perspectives. Two concepts closely related to biographical agency

are biographical work and biographical identity. The concept of biographical work was introduced by Juliet M. Corbin and Anselm L. Strauss (1988, 68, cited in Betts et al. 2009, 27) as meaning ‘putting life back together again’ after the emergence of a serious chronic illness. It is understood as the work done by an individual to come to terms with a major life change, and implies balancing between social constraints and personal agency (Betts et al. 2009, 25–31; Sub-study II). Biographical work is the process of ‘developing more self-understanding as a basis for more reflexive and purposeful strategies’ (Chamberlayne 2004, 32) and of integrating traumatic areas of life into the life story through reflecting on their meaning (Rosenthal 2003, 923–924).

In its most elementary form, biographical work takes place when a person tells another (significant) person about their life, about events and experiences, and about thoughts and feelings. Biographical work can be explicit and conscious but also subliminal, and can be in the form of inner conversations (Schütze 2009a, 160–161). As I understand it, the concept of biographical work emphasises reflection and reflexivity, whereas biographical agency emphasises intentions, decisions and actions. Biographical work is necessary before a person can take biographical action (cf. Schütze 2009b, 69). Biographical work often requires relational support and interrogation (Chamberlayne 2004, 32), which can be provided by professional social workers (Sub-study VI).

Some biographical researchers use the concept of biographical identity, based on a wider notion of self and developed in social relationships over the life course, to distinguish from a more situational concept of identity (Betts et al. 2009, 21). Biographical identity is the product of biographical work and expresses the relationship between identity development and life history (*ibid.*, 12–13). Biographical structuring and identity development become visible in the story a person tells about their life. The concept has connections with loss of self (cf. biographical disruption) and biographical self-conception. Biographical identity can be understood in terms of what happens to it when it is threatened and has to be reconstructed, as is often the case in major life changes due to chronic illness or long-term disability. The self-historical shape of a person’s biographical identity is formed by their overall grand narration, which means that a person’s biographical identity is shaped retrospectively (Schütze 2009a, 164).

Biographical identity is reconstructed through biographical reviewing, which includes two aspects: first, systematically re-evaluating the biographical past and integrating it into the new self-understanding, including personal future perspectives; and second, believing in one’s own capacity to work on the new situation (Betts et al. 2009, 23–24).

The concept of biographical identity seems compatible with the idea of identity in psychosocial theory, which does not see identities as ‘essential, unchanging or rational’ or as ‘primarily self-chosen or available for infinite revision’ but as ‘messy and in process’; as having authenticity, depth and value (Frost 2015, S92). With the help of biographical work and biographical agency, a person reconstructs their biographical identity; for example, at the onset of a life-changing chronic illness.

In all biographical action, social constraints and opportunities play a big role. This context sees social constraints as mainly consisting of the direct and indirect consequences of major health problems and their treatment in daily life, for example, family life, work capacity, leisure activities, and the economy. Opportunities in the social environment may, for example, pertain to education, work and leisure, and to finding new or strengthening existing relationships. Social constraints and opportunities together with the individual’s capacities and perceived life chances form a unique whole in which the individual can exert biographical agency.

5 Biography in social work practice

The global definition of social work maintains that ‘social work engages people and structures to address life challenges and enhance wellbeing’⁸. In practice, the balance between the two – people and structures – is often difficult to define. Research has shown that deterministic thinking is quite strong among social workers (Kallio et al. 2013; Kyllönen 2004); however, social workers are supposed to empower their clients to make necessary life changes (DuBois & Miley 2005; Romakkaniemi & Järvikoski 2012; Rose 2005). It has also been proposed that social work should orient itself towards a life politics perspective in order to support clients in their life planning and mastery over their lives (Ferguson 2001, 42). But this life politics perspective has been criticised for placing too great an emphasis on human agency and not enough on structural constraint (Garrett 2003, 381).

Biographical scholars (Fischer-Rosenthal 2000; Riemann 2003) argue that the two contradicting perspectives – the micro-macro gap, the subject-object divide – can be united by the concept of biography; understanding the perspectives of subject and society as ‘two dimensions of the same reality’ (Roer 2009, 186). In order to better understand clients and how to intervene at different life stages, knowledge of human development is often considered essential for social work practitioners (Thompson 2005; Wilson et al. 2011). As early as the beginning of the last century, Mary Richmond (1917) saw biographical knowledge as important for establishing a ‘social diagnosis’. However, in the 1950s–1970s, with the quest to put the ‘social’ back into social work (cf. Healy 2014, 67), biographical knowledge was hardly considered relevant (cf. von Bertalanffy 1968, 219, cited in Healy 2014, 117). The biographical turn in the 1980s aroused new interest in life history in both research (Nilsen 2008) and professional practice (Chamberlayne et al. 2000, 2). In the following, I review three overlapping types of professional practice that often use biographical methods and material, from different perspectives. These are the life course, the narrative and the reconstructive approaches.

5.1 Life course approaches

A key debate in the discussion on human development is whether people are mainly determined by their biological inheritance or shaped by their environment (Wilson et al. 2011, 134). Social work, for the most part, generally acknowledges the impact of environment. The life course perspective in social work, as described by Elizabeth D. Hutchison (2011), takes a broader view than many of the theories on human development and pays great attention to the impact of historical and social events on human behaviour. The focus is on understanding the historical contexts of clients' lives over time, without taking a strictly deterministic stance. Human agency, that is, people's strengths and capacity for change, is also acknowledged.

When social workers implement a life course perspective, it helps clients 'make sense of their unique life's journeys and to use that understanding to improve their current situations' (Hutchison 2011, 36). The starting point is major life experiences related to the life phase in which they occurred. Trajectories, transitions, life events and turning points are important, as are the ways in which the lives of family members are linked across generations. People's lives are seen to develop differently depending on gender, social class, location, time and culture. The life course approach is particularly useful in the social work assessment process for gaining understanding of a client's situation (Hutchison 2007, 1).

In the life course perspective, the situation of individuals with a chronic illness or disability is experienced differently, and it has different implications depending on the life stage in which the person is (Jeppsson Grassman et al. 2012). Being diagnosed with a chronic illness can be a life transition, bringing changes to family and work roles and statuses, or it can be a turning point that sets the life trajectory off track. The purpose of social work interventions is to help clients get their life course trajectory back on track. One limitation is that this perspective does not link the micro world of individual and family lives to the macro world of social institutions and formal organisations. (Hutchison 2011.)

What then, is the difference between the life course perspective and the biographical perspective in social work practice? I think that a key aspect here is the use of the term life journey rather than life story in the definition of the life course perspective. This perspective focuses on reconstructing a person's life course from the outside

for assessment, whereas the biographical perspective aims to make meaning of and reconstruct, through dialogue, a person's unique human life as a conscious experience related to identity and, if possible, to use this reconstruction process not only for assessment but also for intervention.

5.2 Narrative approaches

Many biographical approaches use narratives. Narrative approaches build on postmodern theories (Healy 2014, 206). Their focus is on stories; people give meaning to their lives by storying their experiences (Riessman 2008). Narrative thinking in professional practice is two-fold. On the one hand, narrative is a cognitive structure and storytelling a form of communication; narrative ideas are used for eliciting important information and for meaning-making. Professional practice using this type of narrativity could be described as narrative-informed (McLeod 2006, 202; Nousiainen 2016). On the other hand, narrative can be seen as performance, referring to ideas of narrative therapy (White & Epston 1990), where the intention is to address power issues by deconstructing dominant, possibly marginalising cultural stories and creating an alternative narrative; this type of professional practice could be called post-psychological (McLeod 2006, 202). In professional practice both types of narrative thinking are used.

In life story work (Ellem & Wilson 2010), clients are helped to reconstruct their life stories, make sense of major life events and identify the changes required for the future. This type of work can use life story books, for example, in the care of people who are unable to express to others who they are (Middleton & Hewitt 2000), or in art-based activities with children in residential care (Känkänen & Bardy 2014). 'Life history work' (Hatch & Wisniewski 1995, 125), analysing the social, historical, political and economic contexts of a life story, is done by the researcher in collaboration with the interviewee (Goodson 1995). In social work, this would imply, through dialogue with the client, placing the personal life story within a larger context.

In reminiscence work (van Puyenbroeck & Maes 2006; Saarenheimo 1997), people in a group tell each other memories from their lives. Elderly people like to talk about

their lives, hoping to have their life story validated and the positive aspects reinforced (Molander 1999). People who have survived extremely hard war experiences can benefit from talking about them even decades later (Tuomaala 2008). In bereavement counselling, a model has been suggested which, instead of dealing with grief by working through emotion with the goal of moving on without the dead person, encourages the grieving person to talk with people who knew the deceased, thus constructing a story that includes the dead person in their current lives (Walter 1996). (Sub-study IV.)

Karen Dawn Roscoe and colleagues (2011) outline a model of narrative social work as a reflective conversation, in which the social worker and client deconstruct their own narratives and collaboratively re-author a new narrative in three phases of work: engagement, deconstruction and re-authoring. Some discussions combine the postmodern perspective with a critical realist perspective in order to acknowledge the influence of structural factors on people's narratives.

Biographical narratives as autobiographical storytelling are closely related to people's lives, not only because they provide biographical information but also because they offer a perspective and a process that shapes and gives meaning to people's life experiences (Baldwin 2013, 133). Identity and identity reconstruction are important in both the narrative and biographical approaches. However, in biographical approaches, as they are defined in my research, the study of stories includes the study of individual and collective life processes; whereas in narrative approaches, the object of study is merely the story, often about a specific problem in a person's life.

5.3 Reconstructive approaches

Reconstructive social work is a concept developed by German scholars (Rätz & Völter 2015; Völter & Reichmann 2017) for research, practice and professional self-reflection. It is based on the concept of 'Verstehen' (understanding; interpretation; reconstruction) as a reconstructive perspective in qualitative research. In reconstructive social work, it is important to attempt to rationally grasp, without appraisal, how things have transpired and how they are connected, that is, the inner logic of actions

or institutions. This applies to social workers' understanding of their clients' thinking and behaviour and to social processes, as well as to the professionals' own self-understanding. Here understanding does not mean unconditional acceptance, showing mere empathy or knowing better. What is to be reconstructed in reconstructive social work is the meaning and the significance of actions and behaviour. (Völter 2017.)

The first example of reconstructive social work was social case work as developed by Mary Richmond (1917; 1922). Later, the Chicago School (Riemann 2015), symbolic interactionism (Griese & Griesehop 2015), the phenomenology of Alfred Schütz (1967) and the work of Barney G. Glaser and Anselm L. Strauss (1965) played a great role in the development of reconstructive social work. The German sociologists Gerhard Riemann (2005) and Fritz Schütze, who worked with Strauss, introduced a type of workshop for reconstructive social research and social work for German university students. In fact, in reconstructive social work, ethnography takes a metatheoretical and metamethodological stance. (Völter 2017.)

Reconstructive social work generally draws on case reconstruction and often uses narrative methods. By studying the structure of how actions and processes of actions are symbolically expressed – orally, in text or in pictures – it is possible to reconstruct different perspectives of the underlying thoughts and actions. Two different orientations can be distinguished. One is the conception and methods of biographical and pedagogical diagnostics, in which case analyses, based on case records and narrative interviews, are performed by researchers and social workers before the results are discussed with the clients. The other orientation is the process- and development-oriented dialogic work with clients, the aim of which is to further the clients' life plans by involving them in a knowledge-creating process which builds hypotheses about action patterns and structures and develops solutions through dialogue. (Völter 2017.)

Reconstructive social work is not a complete ideology, but a holistic idea that is based on social science and can be successfully combined with other concepts, theories, methodologies and methods. For instance, it can be combined with client-centred conversation (Rogers 1961), life world-oriented social work (Thiersch et al. 2002) and systemic social work (cf. Fagerström & Karvinen-Niinikoski 2013). It is possible, for example, to understand in a reconstructive way and act in a systemic way. (Völter 2017.)

Social workers are encouraged to develop a research-minded attitude and practice, and to see the complexity of clients' individual problems in a larger social and

societal context. The theoretical and methodical opportunities for professional (self) reflection imply an attitude that enables social workers to review problem situations, case constructions, interviews, interventions and documentation; and to learn from crises, impasses and disruptions. Narratives about practice, writing and analysing ethnographic practice protocols, narrative supervision, and narrative peer supervision are recommended. (Völter 2017.) The emphasis on self-reflection in reconstructive social work resembles the discussions on critical reflection and reflexivity that are also topical among other social work scholars (Karvinen-Niinikoski 2009; Thompson & Pascal 2012).

One type of reconstructive professional practice is biographical counselling⁹. Sandra Betts and colleagues (2009, 6–7) describe two types of biographical counselling with clients in vocational rehabilitation: long-term counselling that consists of narrative interviewing and biography analysis, aiming to help clients strengthen their biographical abilities to work through their difficult life experiences; and short-term counselling that sensitises clients to biographical considerations and increases biographical self-understanding in general. Short-term biographical sensitising resembles the idea of working with biographical lenses mentioned in my final sub-study (VI).

For long-term biographical counselling, Betts and colleagues (2009) list six tasks: reminding clients that they have a unique biographical identity; helping them understand their biographical structuring and focus on trap situations; helping them reflect on distractions from identity development and on self-theoretical distortions in their biography; supporting clients in coming to terms with the problem situation at hand; helping them see their biographical resources and vulnerability dispositions; and encouraging them to believe in their own capacity to work on the problem situation. Some of these tasks are similar to general tasks in health social work practice; other tasks imply deeper analysis of clients' biographies. Biography analysis (Schütze 2009b) aims to reconstruct the gestalt of the narrator's biography, using the biographical process structures mentioned earlier. The idea is that clients' biographical work advances when they are able to see the gestalt of their own life history.

9 The term 'biographical counselling' is also used by, for instance, psychotherapists with a diploma in biographical counselling based on the ideas of anthroposophy (Professional Association of Biographical Counsellors 2017). For a discussion on the use of the English term 'counselling' in this context, see Barker 2009, 118–119; Coulshed & Orme 2006, 107–108.

Biographical case reconstruction, as suggested by Wolfram Fischer (2004), is intended to help individuals strengthen their biographical abilities to cognitively work through their experiences. This method consists of three phases. First, based on biographical-narrative interviewing, the social worker, in interaction with the client, reconstructs the case. In the second phase, the social worker, preferably through professional discussions with colleagues, analyses the interview by case reconstruction and interaction analysis and looks for new realistic options for the client. In the last phase, the social worker takes the results of the analysis back to the client and discusses the options that promote meaningful changes in their life. Fischer emphasises that the social worker should not confront the client with their expert opinion but, through an interactive process, should discuss the most pertinent results of the analysis. This and the long-term biographical counselling method described above appear to represent the diagnostic type of reconstructive social work.

C. Dorothee Roer's biography work (2009; 2015), on the other hand, emphasises process and dialogue with the client more than diagnostics. Her model of biography work is based on Leontiev's (1978) activity theory, which sees activity as the continuous process of interplay between subject and object. The clients are biographical actors, who are capable of changing their lives and their circumstances; during their lives, they create relations between themselves and their environment; and, through this process, they produce their biography. According to the model, people have the potential to become better experts of their own lives. The task of the social worker is to reconcile the perspectives of human agency and structural constraints and to support clients in finding their own strategies for reconstructing their lives and life conditions and for developing their identity; the goal is an intervention that fits into the client's life plan. This is achieved by integrating stories and history and by reconstructing the biography with all its contradictions. The methods used are mainly narrative. In addition to autobiographical interviews, biography work can also be done around certain themes and using nonverbal methods such as painting, drawing, collage and theatre (Roer & Maurer-Hein 2004, 57). A central aspect of the necessary biographical attitude is respect, which in this context does not mean emotional identification, but respect for the unknown (cf. Riemann 2005), and respect for the autonomy of another person and their own life plan. A political perspective is important; biography work based on A.N. Leontiev's activity theory is historical-materialistic.

Another type of reconstructive social work that emphasises dialogue and the relationship between the social worker and the client is dialogic biography work (Köttig & Rätz 2015). Its aim is, through narration-generating communication, to stimulate clients' self-reflection and their understanding of the logic of their thoughts, interpretations, and actions in the light of their biographical experiences. Narrative-reflexive counselling (Schulze 2015) in turn takes a social-critical stance in deconstructing power and identity issues and dominant narratives with an aim to recognise alternative ways of living. In this way it resembles narrative approaches that focus on power issues (cf. Milner & O'Byrne 2002, 153). The narration of older and newer stories can lead to the development of new perspectives and new solutions. Another aim is to influence processes of social, economic and other exclusion on the societal level. Dialogue and respect are important here, too. This kind of counselling is rooted in a subject- and structure-analytic concept of biography, and in reconstructive social work, based on ethnography and conversation analysis.

As well as in individual-level work, biographical methods can be used in community work. Catherine Delcroix and Lena Inowlocki (2008) describe an action research project in which social workers in a deprived neighbourhood in France used life story interviewing for self-reflection in order to better understand the immigrant fathers of young people showing delinquent behaviour, drug trafficking and addiction. The action research helped improve the fathers' relationships with their children and help the sons and daughters see themselves in a historical context connected to their fathers' ambitions for their children rather than as victims of an unjust society.

5.4 Criticism

The aim of this chapter has been to show that biographical approaches to practice can have very different perspectives. The life course approach looks at people's lives from the 'outside', focusing on turning points, transitions, life events, and life phases. The narrative approach in turn focuses on the stories people tell about their lives, and the reconstructive approach focuses on the significance of actions and behaviour from the 'inside'. All these approaches can be used for assessment. Storytelling can also have a

therapeutic effect, and post-psychological narrative practice implies addressing power issues as intervention.

The criticism of biographical approaches in professional practice has concerned their effectiveness (Barker 2009), the risk of individualising social problems, supporting egocentrism values (Behnisch & Kämmerer-Rütten 2009), and the expression of social expectations of normalisation (ibid.; Kyllönen 2004). The risk of overinterpreting biographical information has also been mentioned (Bornat 2008; Reichmann 2010). (Sub-study VI.) Some scholars warn that continuously focusing on the past can sometimes be destructive. Karen Neuman Allen and Danielle F. Wozniak (2010) claim that retelling traumatic experiences may risk strengthening clients' negative identifications as victims or survivors of abuse. Beyond a certain point in recovery, clients may benefit from an approach that helps them integrate a bad experience and build up a different kind of identity. The aim of health social work, of course, is to avoid becoming stuck in the past and to plan for the future, while seeing the present as informed, but not determined, by the past.

6 Biography in health social work practice

What does it mean for a previously healthy young person to see their future plans suddenly crushed as a consequence of being diagnosed with a serious chronic illness or severe impairment? For older people, chronic illness and impairment may also mean that daily routines radically and permanently change and that constraints are imposed on work capacity, family life, travelling, leisure activities and finances. Moreover, as the illness progresses, the person may have to increasingly rely on others for help. As noted before, the concept of biographical disruption is problematic, but for most people, being diagnosed with a serious chronic illness is likely to imply at least a turning point in their lives.

People who have just learned that they have a chronic illness that will lead to a major life change often want to talk to someone about their thoughts and anxieties regarding the future. Through dialogue with, for example, a health social worker, they can reflect on their life situation and work on setting new life goals (cf. Romakkaniemi & Järvikoski 2012). For the worker to obtain an overview of the patient's life situation and better understand the implications of the chronic illness or impairment in question, it is often relevant to know something about the person's recent past and their plans and hopes for the future. This is where the biographical perspective comes into play.

In the previous chapters (4 and 5), I discussed biographical concepts and approaches as related to research and social work practice in general. This chapter focuses on health care as the setting for biographically informed social work practice and deals with the first research question set for this summary article:

- What might applying the biographical perspective in health social work practice imply?

The chapter discusses the biographical perspective in health care settings and suggests defining biographically informed health social work practice using the concept of biographical agency; it considers biographical interviewing as an intervention method; examines the interviewing relationship in biographical approaches; and discusses prerequisites for biographical interviewing and ethical considerations.

6.1 Biography and the health care setting

When implementing biographical research methods in social work practice, the specific requirements set by the professional practice setting must be considered. The main differences between research and practice concern the professional responsibility and accountability of social work practitioners for their clients, who come to them expecting help with their problem situation. The differences generally concern the institutional context, the reason for and purpose of biographical-narrative interviewing, the narrative capacity of the interviewees, the structure of the interview, the interviewing relationship, the time frames, and the possibility of follow-up. (Sub-study V.)

In addition to the other contextual factors that influence biographically informed health social work practice, the prevailing health paradigm assigns social work a role that may or may not be compatible with a biographical perspective. Biographically informed health social work practice appears to be more or less possible under most of the five health paradigms mentioned earlier (Section 2.4), at least with some expansion of the social work role. The dominating biomedical health paradigm seems the least compatible. Even though the history of a patient's illness and symptoms is generally seen as important in making a medical diagnosis, life history and life story information is most likely to be considered irrelevant in this context. However, if it does not interfere with the biomedical care, a well-argued biographical perspective proposed by the social worker would hardly be completely rejected.

As mentioned before, the currently quite popular biopsychosocial health paradigm, which takes into account biological, psychological as well as social factors, does not include the time dimension. Adding a biographical aspect, that is, focusing on the individual as a life story, as moving on a biographical track, or viewing the different dimensions of the biopsychosocial model as aspects of one fundamentally biographical whole, has been suggested (cf. Svenbro 2005, 65). The dimension of time in the social determinants of health paradigm fits in well with the life course perspective: life histories can provide important knowledge about the socio-economic determinants of health over the life course.

The salutogenesis theory also seems compatible with a biographical perspective in that it provides a view of what maintains health over time. This can be important knowledge for social workers when deciding on how to encourage clients' biographical

work and biographical agency. Finally, by embracing the interplay between social constraints and personal agency over time, the biographical perspective is by definition holistic. A holistic health paradigm including the biographical perspective could imply viewing social work clients as biographical actors, relating to them in a dialogic way, and acknowledging their own view of wholeness.

6.2 Supporting biographical agency

As in biographical sociology, different concepts, methods and theoretical stances can also be applied in biographically informed social work practice. Several biographical concepts are relevant in health care, in which a holistic view of patients' situations is often significant. In my sub-studies (e.g., Sub-study VI, 8), I described social workers supporting their clients' biographical work, that is, encouraging the reflective work needed to come to terms with a major life change. In this summary article, I want to emphasise clients' perceived and actual capacity for biographical action, and that the support of this capacity is the core task of health social workers. As a definition of biographically informed social work practice, I propose the following¹⁰:

Biographically informed social work views clients as biographical actors in their social world. The purpose of the work is to support clients' biographical agency by encouraging their biographical work and helping them reconstruct their biographical identity through a holistic and dialogic process approach. This is done by suggesting different ways in which to tell their life story, by listening, by offering opportunities for systematic reflection, and by helping them construct a means for dealing with the past and finding resources for planning the future. The work also considers social constraints and opportunities. Interventions and interpretations are based on social work practice methodology. Knowledge about the biographical needs of client groups also enables work on a structural level.

10 In the definition, I draw partly on the suggestion of one of my respondents in Sub-study VI, 178.

This definition is written with the generalist health care setting in mind but is possibly also applicable in other social work settings. Biographical approaches have been useful in different fields of health social work such as psychiatry, addiction treatment, gerontology, and vocational rehabilitation; in different types of practice, in assessments and interventions, in both long-term and short-term counselling; and with clients of different ages (Sub-study VI). Here I imply that biographically informed social work practice takes into account institutional circumstances and professional responsibilities and accountability, and that explicit psychological interventions and interpretations are limited (Sub-study V).

As the core concept in biographically informed health social work practice, biographical agency must be defined more specifically. Drawing on Hitlin's and Elder's (2007) concept of life course agency, on Heinz' (2009b) notion of the biographical actor, and on Betts and colleagues' (2009) notions of biographical work and biographical identity, I suggest the following definition:

Biographical agency in social work practice refers to the ways in which individuals try to shape their lives in a long-term perspective within prevailing historical, social and biological conditions, and to their ability to make choices at turning points. It integrates life history and life perspective, perceived options and situational circumstances; it contains a self-reflective belief about one's capacity to achieve life course goals; it implies that people are capable of the biographical work necessary for biographical action, and that every person has a unique biographical identity. Biographical agency is expressed in the person's life story, usually produced in a biographical interview, but biographical agency can also be supported without detailed knowledge of the person's life history or life story.

The idea of biographically informed health social work practice as supporting clients' biographical agency is shown in Figure 2. The biography of an individual is symbolised by an arrow from the past through the present towards the future. It draws on biographical facts and life history (lived life as experienced) and is built over time in constant interplay between biographical agency on the one hand, and social constraints and opportunities on the other. At any given moment in the present, the interplay between biographical agency and social circumstances can be expressed in a life story (life as told).

The social constraints in this context are seen as caused partly by serious health problems and impairments requiring, for example, medical treatment and dietary restrictions; causing mental and physical weakness, and affecting family life, work and study capacity, social activities, and economic situation. In biographically informed social work practice, the past is inherent in the present in three ways, which all are important in health social work: social workers elicit biographical facts, listen to clients' life experiences (life history) and learn how clients view their life at the present time (life story). For simplicity, in the following, I use the term 'life history' to embrace both biographical facts and life experiences.

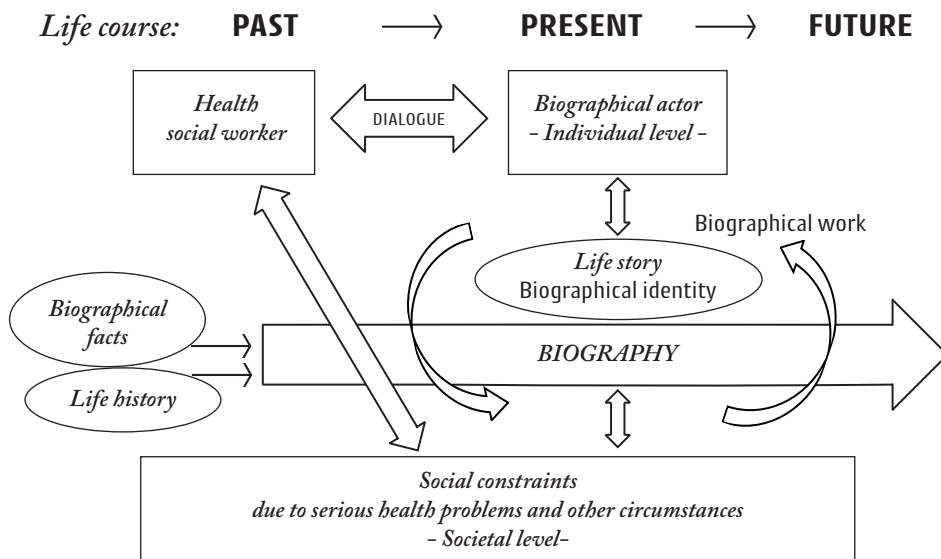


Figure 2 Biographically informed health social work practice.

In specific situations, health social workers interact with clients through dialogue, aiming to support clients in enhancing their biographical agency. In practice, this generally means working with the clients' relatively explicit life stories, both as meaning-giving narratives and as accounts of individual life processes. The clients are encouraged to exert personal agency in order to pursue their personal life projects, to discover resources and opportunities, and to change possibly destructive social circumstances. Despite their biographical agency, clients cannot, of course, be expected to control every aspect of their future. Social workers often exert proxy agency by

working directly with the social environment in order to mobilise resources and to change or alleviate the negative impact of social constraints on clients' lives by, for example, negotiating with authorities and organisations.

Research showing a connection between personal control and health perception is interesting from a health perspective (Krause & Shaw 2003; Suominen 1993). If we believe, like Hitlin and Elder (2007), that biographical agency is affected not only by individuals' actual capacity to act with long-term implications, but also by their self-reflective belief in this capacity, encouraging clients to discover and trust their capacity to achieve life course goals and to do biographical work becomes crucial. Social workers seem to appreciate the biographical interview as a means through which to create a space for clients to reflect and for themselves to listen and better understand the clients' behaviour and reasoning (Sub-study VI). Where there is no explicit life story, biographical agency can still be supported by, for example, validating and confirming any mention of life issues (cf. biographical lenses in Sub-study VI) and developing interventions that constitute positive turning points in the clients' lives (cf. Hutchison 2011, 37).

According to Hitlin and Elder (2009), the different types of temporal agency overlap. This means that in order for a person to be able to adjust in the long-term to a major life change caused by chronic illness, they have to make adjustments to everyday life immediately, exerting pragmatic agency related to, for example, new medical treatment, dietary restrictions and the use of new devices. Taking on new roles in the family and at work also requires pragmatic agency until the roles become routine and can be performed by exerting identity agency. So, supporting biographical agency implies also supporting pragmatic and identity agency through a holistic approach.

Biographical work as internal conversations requires reflexivity, and individuals have different capacities for and ways of being reflexive (cf. Sub-study V). All the four modes of reflexivity identified by Archer (2007, 93) are likely to be found in health social work clients: being reflexive by talking with other people (communicative reflexivity), being reflexive in inner dialogue with oneself (autonomous reflexivity), being reflexive about one's own reflexivity (meta-reflexivity), and having great difficulty being reflexive at all (fractured reflexivity). People with fractured reflexivity may find it considerably difficult to tell a coherent life story; internal conversations may add to personal distress and confusion instead of leading to rational action (cf. Archer 2007, 96).

If the state of fractured reflexivity is temporary, caused by, for example, a stressful situation, the social worker may help the person overcome this state of 'passive agency' by listening to whatever they are prepared to tell about their life and by encouraging them to do biographical work. If the state of fractured reflexivity is more permanent, biographical agency may have to be supported in other, more practical ways. People who, for other reasons, are not capable or willing to produce biographical material about their life may be in a state of exerting agency as enduring, that is, living 'one day at a time'. Of course, this should also be respected.

Biographical work happens when a person tells someone their life story. Most people are able to tell a story and reflect on their life with some help; social workers can facilitate clients' biographical work.

The biographical method gives the client space to reflect, time for a genuine meeting. (Social worker L, rehabilitation) (Sub-study VI, 8.)

During the process of storytelling, clients are free to structure their biography and to do biographical work. Clients who find themselves able to reflect on their situation are more likely to gain belief in their own capacity to solve their problems.

With biographical tools it is possible to ask questions like: Who am I? Where do I go from here? These questions enable clients to study their own identity more closely. (Social worker K, rehabilitation) (Sub-study VI, 8.)

Patients facing a major life change should be given the opportunity to tell their story to a professional if they so wish. Health social workers can provide support by developing their listening skills.

I have noticed that it is difficult for me to just let the client talk; I often want to take a more active hold. Here I have some learning to do. (Social worker B, psychiatry) (Sub-study VI, 8.)

Moreover, by putting clients' life stories into a larger context and providing a holistic view of the clients as biographical actors in their social world, a biographical approach in a trustful relationship seems to encourage social workers' views of their own professional role and to strengthen their professional identity. (Sub-study VI.)

In this context, the question arises as to whether biographically informed social work practice implies counselling. I will not go into a discussion on the differences between

social work and counselling (cf. Coulshed & Orme 2006, 105–131; Wilson et al. 2011, 347) but will stress that I agree with Neil Thompson (2005), who maintains that social work practice often involves an element of counselling in terms of ‘helping people understand their situation, their feelings and their options’ (p. 69). Biographically informed health social work practice may have therapeutic effects but, as defined here for the Finnish context, is not psychotherapy (cf. Healy 2014, 68; Sub-study V). In supporting clients’ biographical agency, biographical approaches per se are not always sufficient, and other methods may have to be used. In such cases, social workers can draw from different social work practice theories.

6.3 Biographical interviewing as intervention

Since assessments are simultaneously interventions (cf. Milner & O’Byrne 2002, 1–7), the way in which life history information is elicited has implications for the social work intervention (Sub-study VI). Using a checklist, for instance, is quite a different intervention to open, narrative interviewing (cf. Martinell Barfoed 2014). Viewing clients as biographical actors and supporting their biographical agency generally implies, if not eliciting a whole life story, at least some reviewing of the recent past, present and future. Referring to the biographical-narrative interview used in research, some scholars (cf. Riessman 2008, 25; Romakkaniemi 2014, 150) point out that, rather than talking about a very wide time frame, interviewees often find it easier to talk about specific times and places. This is probably true for many social work clients.

In social work practice, biographical interviewing and analysis are probably mostly a combination of different methods. In a social work interview, certain issues generally have to be discussed, and, therefore, at least part of the interview tends to be fairly structured. Social work interviewing is often semi-structured around certain topics in a combination of narrative and thematic methods (cf. Scheibelhofer 2008), and conducted more through dialogue than the biographical-narrative research interview (cf. Bornat 2008). (Sub-studies V and VI.) In addition to life stories, other sources can be used for biographical reconstruction. Welfare and health care institutional agency files, case notes, patient histories and letters may reveal major life events that are not mentioned in the interview but which may have implications for the social work assessment. Life lines, network maps, time circles, collages, photos, calendars, diaries,

memory objects, pictures, drawings, music, or drama (cf. Kohtamäki & Palomäki 2010; Roer & Maurer-Hein 2004) can also be used.

In generalist health social work, detailed biography analysis is hardly needed or even feasible, since it would require advanced knowledge of research methodology and more time than practitioners can normally spend on one case. Furthermore, it would position the professional in an expert role, which is not desirable (cf. Barker 2009). Commonly, in a comprehensive psychosocial assessment, the interview is analysed in collaboration with the client as a case study, examining themes such as work situation, work history, education, family situation, economic situation, and future outlooks. Researchers generally interpret life stories according to their theoretical research framework. In generalist health social work, priority is usually given to clients' own interpretations, coming close to the position of oral history with its commitment to giving the oppressed a voice (cf. Bornat 2008), or in this case, letting clients' voices be heard. Depending on the purpose of the social work intervention in question, the client's own interpretation can and, of course, should be challenged¹¹.

In order to better understand how clients view their lives, practitioners may analyse the structure, the gestalt, of the life stories with the help of, for example, the biographical process structures. Biographical action schemes in a life story are important signs of personal agency and strengths to build upon. Identifying negative trajectory processes that express weak agency may reveal passive reactions to outer events that cause long-term severe suffering. In such cases, social workers may attempt to provide relevant support at different stages of the trajectory and help clients turn the development in a more positive direction. They may help clients reorganise their life situation, learn to live with the trajectory, or plan for a life in which the trajectory can be avoided. At best, the process strengthens the client's biographical agency and they can act more rationally. Signs of a biographical metamorphosis in a life story are a creative inner development, a feeling of having lost an old view but not yet having found a new one. (Sub-study III.)

11 In my last sub-study (VI), I concluded that in social work, 'interpreting life stories [...is ideally best done primarily by the users themselves]' (p. 12) without arguing this point further. My attention was kindly drawn to this neglect by Tom Wengraf (March 31st, 2015, personal email), who pointed out that I should have invited the reader to also consider other possible positions. He wrote that 'people come to psychotherapists and to thoughtful social workers precisely because their own self-description and their own self-storying does not enable a proper understanding of themselves and an adequate self-transforming practice to occur' Wengraf's comment is understandable in a psychodynamic and psychotherapist perspective and draws attention to the fact that biographies can indeed be analysed from different theoretical perspectives and in different contexts. I am very grateful to Tom Wengraf for his comment.

In social work practice, biographical interviewing is used not only for eliciting biographical information and life stories but also as a tool for change. Often these two purposes are intertwined and work simultaneously: eliciting biographical information through autobiographical narration entails biographical work. The therapeutic effect of storytelling to an active listener resembles the benefits of narrative strategies validating clients' life stories in social work described by Jan Fook (2012, 156). (Sub-studies V and VI.) Biographically informed social work practice, as defined in my research, takes clients' past into account without 'digging it up' (see section 7.5).

6.4 Dialogue with biographical actors

Biographical methods are a tool that enable practitioners to work in a client-centred instead of a system-centred way (cf. Betts et al. 2009). The dialogic and interactive nature of biographical methods has indeed been ascertained (cf. Apitzsch et al. 2004; Völter 2017), which means that dialogue and a trustful relationship are necessary for supporting clients' biographical agency and encouraging their biographical work (cf. Betts et al. 2009, 31–32; Riemann 2003, par. 24). Since health social workers seldom work in statutory tasks, it is generally fairly easy for them to take a supportive role and aim to build shared agency with their clients.

In social work, the importance of working in and with the relationship has once again become acknowledged, after having been seen as less important for some time (cf. Folgheraiter 2004; Ward et al. 2010). This relational turn aims to acknowledge the balance of the psychological and social perspectives needed in social work practice (cf. Ruch 2010). The relational attitude has been described (cf. Folgheraiter 2004, 112–114) as an inner strength, a feeling of self-confidence, which enables practitioners to accept their own weakness and uncertainties and to perceive and accept the client's strength. Relational here means horizontal exchange: both give and both learn. The relationship is neither directive, that is, directed by the social worker, nor non-directive, that is, directed by the client. However, a completely equal relationship is hardly possible, because the social worker is present as a professional as opposed to a private person, and the focus of the work is on the situation of just one of the people involved – the client.

Relationship-based approaches refer not only to social workers' relationships with individual clients but also to clients' relationships with their network and social circumstances, and to social workers' relationships with the socio-political context in which they practise (cf. Wilson et al. 2011, 5). Today, the relationship-based approach is challenged by standardised assessment instruments, such as ASI (Addiction Severity Index), which has been introduced in some countries to improve and measure the outcome effects of social work (cf. Martinell Barfoed & Jacobsson 2012). ASI is a questionnaire that guides and restricts the interaction between the social worker and the client. It leaves little if any room for the client's free narrative, and thus their life stories become fragmented (cf. Martinell Barfoed 2014) instead of being dealt with holistically.

When building relationships with clients for the purpose of dealing with biographical problems involving personal identity issues, certain professional paradoxes are emphatic (cf. Betts et al. 2009). Generally, these paradoxes pertain to the difference between the power and formal knowledge of the professional and the client, to the conflict between generality and specificity, and to the possible differences between the interests of the institution and the client (Sub-study V). The paradox of considering the biographical wholeness of the case on the one hand, and the specific institutional task of the professional on the other, is present in most social work. Social workers in health care, however, may have greater freedom than their colleagues in municipal social services to view their institutional task holistically.

The idea of reconstructive biographical counselling is to let clients determine and make their own biographical decisions in terms of supporting their strengths. However, in reality, there is not always time to wait for clients' biographical decisions. (Cf. Betts et al. 2009.) Building relationships with clients is time consuming and challenging. Kirsi Juhila (2006) identifies four types of relationship between clients and social workers: the normalising and controlling relationship, the companion relationship, the caring relationship, and the interactional relationship. For a biographical perspective to be possible, the last three types of relationship seem relevant. Biographical methods should not be used in situations in which control is exerted (cf. Schütze 2009b, 10). The social worker is a 'co-traveller' rather than an expert. (Sub-study VI.)

Relationship-based practice, as presented by Gillian Ruch and colleagues (2010), is based on psychodynamic, systemic and attachment theories, although the authors point out that relationship-based practice in general is not tied to any specific theory.

In her dialogic interview method, Blomdahl Frej (1988, 160–166), for her part, draws on phenomenology, psychodynamic methodology and a relationistic approach, which aim to reconstruct a gestalt, a whole, of the interviewees' life contexts. She finds this a productive method for creating reciprocal relations between carers and those being cared for. Biographically informed social work practice could effectively draw from the ideas developed in relationship-based social work practice.

6.5 Prerequisites and ethical considerations

The respondents of a study (Sub-study VI) claimed that using biographical methods do not require much more formal knowledge than social work education, some knowledge of biographically informed professional practice, and good knowledge of the social work field in question. As necessary competencies and personal qualities, they reported interactive skills, narrative competence, ethical awareness, self-reflection skills, and an interest in people. In addition to self-reflection skills in general, biographical reflexivity, implying interviewers analysing their own life experiences in relation to interviewees' biographies, is assumingly as important in biographically informed social work practice as it is in biographical research (cf. Ruokonen-Engler & Siouti 2013).

The same study (Sub-study VI) found that the positive attitude of the employer was an essential institutional prerequisite for working in a biographically informed way. Even though they may have a significant, positive impact on clients' situations in the long run, biographical approaches may be considered by the employer as too time-consuming and not very cost-efficient in the short run. For practitioners using biographical-narrative interviewing, continuous supervision in the form of professional dialogue was judged necessary. As a way in which to improve competencies in working with cases, Riemann (2005) suggests case reconstruction analysis with colleagues, looking at cases as self-reflective ethnographers. Experienced social workers seem to be more comfortable with biographical approaches than less experienced workers (Roer & Maurer-Hein 2004). (Sub-study VI.)

Many of the ethical aspects of biographical interviewing and analysis in research (Kazmierska 2004) also pertain to social work (Sub-study V). Social workers are

probably more prepared to deal with interviewees' traumatic life experiences than researchers, but on the other hand, social work clients are generally in a more vulnerable position than the informants of a research study. A researcher has the power to interpret a narrator's life story to readers, whereas a social worker has the power to interpret a client's story to the interprofessional care team. The narrator in a research study seldom has any idea of the focus of the life story analysis, and this may also be true in social work. A researcher has tools for uncovering life experiences which the narrator hides or unintentionally omits. Social work may sometimes have to deal with hidden facts (e.g., suspected crimes), but generalist social workers seldom aim to reveal the unconscious. Problems of an informant possibly being publicly identified through their life story, as can happen in published research, should not be possible in social work unless there are serious problems with confidentiality.

The ethical considerations in biographically informed practice using methods that can be experienced as intruding or tiresome involve ensuring transparency and informed consent, and the interpretation of life stories. Practitioners should be able to provide good reasons for asking clients to tell them their life story; they should tell the client how and by whom the biographical-narrative interview will be used, and in what way this type of extensive interviewing is supposed to improve their situation.

I now give the patient more detailed information about what we are going to do and why. I tell him that the whole team has access to the story, so he knows that the story will not stay between the two of us.
(Social worker C, psychiatry) (Sub-study VI, 10.)

As discussed in the previous section, biographical methods require a trustful relationship; building one may be challenging and time-demanding. Dialogue and transparency is needed to ensure that clients are aware of the purpose, performance, interpretation, and documentation. (Cf. Sub-studies V and VI.) Clients' life stories should not, of course, be used to their disadvantage (cf. Schütze 2009b, 7–11).

A crucial question is what to record in the agency files. A general rule is to document sufficient but not unnecessary information. Documentation in computer programs is becoming more and more standardised, which may mean more fragmented and categorised information. (Cf. Sub-study IV.) Social workers have a great responsibility in deciding how to interpret clients' life stories and how to document them. What biographical information is to be documented has to be decided case by case and must depend on the need and the requirements of the institution in question.

In some ways, open biographical interviewing resembles the free association technique used in psychoanalysis and may sometimes raise memories of traumatic events. Barbara Merrill and Linden West (2009) discuss the 'potentially difficult boundary issue between biographical research and therapy' (p. 175) (see also Golczyńska-Grondas & Grondas 2013). Although it may have therapeutic effects, generalist health social work is not psychotherapy; therefore, practitioners have to be very clear with their clients about the aim of the conversations they initiate. Biographical interviewing is generally not suitable for clients who are in acute crisis and it may be altogether impossible with clients who are non-talkative or who have difficulties reflecting. If the psychosocial support provided by the social worker is not sufficient, the client may need to talk to a psychiatrist or a psychologist/therapist. An advantage in health care settings is that these professionals are generally fairly easily available. (Cf. Sub-studies V and VI.)

6.6 Focus on biographical agency

This chapter has aimed to define biographically informed health social work practice. I introduced the concept of biographical agency for this purpose, suggesting that social work clients be viewed as biographical actors in their own social world, and that the general task of health social workers be seen as supporting clients' biographical agency. Since the implementation of a biographical perspective in health social work practice largely depends on the work environment, compatibility with five health paradigms was discussed. The holistic health paradigm seemed the most compatible.

Clients' biographical agency can be supported in different ways. Typical biographical approaches are biographical-narrative interviewing and topically focused biographical conversations. Dialogue in the interviewing relationship is seen as essential and as promoting shared agency. If extensive biographical interviewing is not necessary or possible, clients' biographical agency can be supported in other ways. As Hitlin and Elder (2007) point out, the different types of temporal agency overlap. Supporting life course (biographical) agency seems to necessitate also supporting pragmatic and identity agency. Health social workers assess what type of agency needs supporting most at different points in time.

As a strength of the biographical perspective, practitioners were able to define their own role as 'co-travellers' rather than as experts (cf. Sub-study VI). A biographical approach enhanced their own listening skills and their understanding of the client's problem situation, and advanced their clients' reflective work. One limitation of the biographical-narrative interview is that it did not work with all clients; it is time-demanding, and building a sufficiently trustful relationship may be difficult. It also requires the understanding of the employer. A weakness of the definition of biographically informed social work practice as supporting clients' biographical agency may be the vagueness of the notion and the fact that it does not propose a clear method for intervention. On the other hand, applying the biographical perspective in the form of viewing clients as biographical actors and supporting their biographical agency is presumably possible with most clients, and can provide social workers with a paradigmatic orientation that strengthens the profile of health social work in an interdisciplinary environment.

7 Biography and social work practice theory

In biographically informed social work practice, the biographical perspective offers a lens for viewing the life situation of a client. However, for intervention a biographical approach alone, such as a biographical-narrative interview, is seldom enough. The approach often needs to be combined with social work practice theories and methods. This chapter examines the compatibility of the biographical perspective with some contemporary social work practice theories, and thus deals with the second research question of this summary article:

- Is a biographical perspective compatible with social work practice theory?

As mentioned in section 3.1, social work practice theory in this context means formal theory intended to guide and explain social work practices (Healy 2014, 111).

Over the years, many theories have been described for social work practice. In the 1920s and 1930s, only two main theoretical schools of social work existed in the Anglo-American countries: the diagnostic and the functional school (cf. Dunlap 2011). Almost a century later, Francis Turner (2011) lists as many as 36 different theories. James Forte (2014, 192–194) encourages social workers to build and use their own integrative multi-theory personal practice model. This means choosing theoretical elements from different theoretical frameworks according to the qualities of the worker and the client and to the practice context. Social workers are indeed known to draw eclectically from different methods and theories (cf. Healy 2014), but theories can be integrated in different ways.

Forte (2014, 183–189) identifies four types of theoretical integration. One is to unite diverse approaches by their common factors, that is, by shared theoretical concepts that transcend specific theoretical frameworks. Another type of theoretical integration is the eclectic approach, in which techniques and the concepts and theories that support these techniques are assembled from different theories but not always used in a systematic or conscious way. This approach has been criticised for selecting and integrating concepts, techniques and principles too uncritically from different theoretical traditions, and for mixing techniques derived from incompatible theoretical frameworks.

A third type of theoretical integration is the assimilative integration approach, meaning the creation of a new overarching conceptual framework into which other theories will fit. Forte (2014) mentions two examples of such assimilative integration: the ecosystems paradigm, in which advocates want to incorporate all knowledge available for social work use, and Forte's own symbolic interactionist framework, which

assimilates ideas from thirteen other theoretical frameworks. The assimilative approach has been criticised for reducing the meaning and value of the integrated theoretical elements, and for forcing incompatible approaches under one umbrella theory.

A fourth type of theoretical integration is the client-directed approach, in which the client rather than theoretical knowledge is the starting point. In this approach, the worker asks the client about their theories of challenge and theories of change. Forte (2014) questions whether clients can be expected to know enough about different theoretical frameworks to provide social workers with informed answers, and whether social workers can be expected to master every theoretical framework that their clients might suggest.

Dorothee Roer and Renate Maurer-Hein (2004) suggest two ways of studying whether the biographical perspective fits in with existing social work practice theory. One is to look at how specific biographical tools, such as the biographical-narrative interview, fit in with different social work theories. The other is to look at how social work theories fit in with the general biographical paradigm. I have tried to apply both these approaches. For that purpose, I propose the following definition of the biographical perspective:

The biographical perspective in social work practice views clients as unique biographical actors in their social world; it pays attention to the client's life course and to the interplay between the individual and social constraints over time. Biographical interviewing is used as a working tool, if indicated and possible. Clients' life stories are dealt with in some way; a holistic and relational view is adopted; and the core task of health social workers is considered to be to support their clients' biographical work and biographical agency in mutually beneficial dialogue.

To compare the biographical perspective with different social work practice theories, I have extracted from each theory only the traits most pertinent for the comparison. The descriptions of the theories are therefore not very detailed. As the previously discussed life course, narrative, reconstructive and relationship-based approaches (Chapter 5 and section 6.4) were considered, by definition, to be compatible with the biographical perspective, I will not discuss them in this chapter. Before studying the compatibility of the biographical perspective with some other social work practice theories, I will say a few words about meta-theory.

7.1 Realist or constructionist?

Critical realism and social constructionism are two meta-theories much discussed in social work. Without discussing these meta-theories further, I note that, as mentioned before, in biographical research, both (critical) realist (cf. Turk & Mrozowicki 2014) and social constructionist (cf. Rosenthal 2015) stances are possible. If, as Greene and colleagues (2010) argue, realist and constructionist ideas can be successfully mixed in social work research, then why not so in (biographically informed) social work practice? Alex Gitterman (2014) maintains that the choice between social work focusing on either the objective or the subjective dimension of reality is false.

Regardless of what stance one takes in the realist–constructionist debate, it seems that in a short-term perspective, some social constraints have to be considered real, in the sense of ‘for the moment unchangeable’. At any given moment, legislation regulating access to social benefits and services, living conditions, family, health conditions, impairment caused by serious illness or accident, and necessary ongoing treatment can all be regarded as real social constraints. Biographical data on life events, including information on education, work, family and health are real bricks for building the future. For a factory worker who has no vocational training it is a real fact that they cannot choose to work as a lawyer. A sick single mother who knows that she most probably will not live to see her children grow up must think about what arrangements to make for their future. An important point for structural social work (Mullaly 2007; Pohjola 2014) is Nilsen’s (2008) argument that social science research highlighting structural power and systematic inequalities needs to look for lived experiences, not only told ones.

To avoid determinism, social work scholars who take a critical realist stance pay attention to the reasons people themselves give for their actions (cf. Houston 2001). This seems to imply listening to people’s spontaneous, sometimes lengthy accounts, perhaps even life stories. Although critical realists acknowledge human agency and people’s capacity to transform their situations, in working to support this human agency and capacity, a constructivist, subjective, narrative perspective seems more adequate. Too strong a focus on argumentative talk risks, on the one hand, increasing the client’s feelings of guilt over their own problem, and on the other, making them expect a solution from the social worker, whom they see as the expert. A constructivist

approach seems more flexible for understanding and responding to clients' life stories. A narrative approach would also look at the interplay between the client and the social worker. Discussions on the client's plans for the future construct reality, while at the same time, real social circumstances affect what can actually be planned.

7.2 Psychodynamic approaches

Some biographical scholars who encourage biography analysis for use in professional practice seem to suggest a psychodynamic framework, which sees the professional as the expert capable of interpreting clients' irrational behaviour (cf. Betts et al. 2009, 17–18). Psychodynamic approaches have had a strong influence on social work practice in Finland (cf. Kananoja & Pentinmäki 1977) as in many other western countries, especially in mental health. After the heavy criticism of these approaches in social work (cf. Coulshed & Orme 2006, 115–117; Healy 2014, 66–67), many practitioners became apprehensive about using any approach that touches on a client's past life. They may have feared that by focusing too much on a client's past, they would fall into the psychodynamic trap of diagnostics and psychopathology. They may also have felt a lack of sufficient competence to deal with the traumatic experiences that often arise in clients' life stories. (Sub-study IV.)

Today, many social work scholars acknowledge that important knowledge can be drawn from psychodynamic approaches regarding, for example, the social worker/client relationship (cf. Coulshed & Orme 2006, 118; Healy 2014, 68), the importance of emotions (Howe 2008), and that it is not always possible nor desirable to avoid talking about a client's past. Both biographical and psychodynamic approaches pay attention to the past of an individual; both emphasise subjectivity (cf. Cooper 2004), the worker/client relationship, and a listening, accepting attitude (cf. Milner & O'Byrne 2002, 96). Psychodynamic approaches see the insights gained through the analysis of early experiences as having an empowering effect (cf. *ibid.*, 95), and thus psychoanalysis can be seen as a kind of biography work in which healing effects take place through the very life-story telling itself (cf. Rosenthal 2003).

Ela Hornung (2010), a historian and psychoanalyst, in comparing biographical-narrative interviewing in oral history research with interviews conducted at the start of psychoanalytic therapy, found that both interview types follow a principle of openness, even though the psychoanalytic interview is thematically more open. The aim of both types of interview is to collect life history data, but psychoanalytic interviewers are also interested in symptoms, conscious and unconscious motives for seeking therapy, unconscious resistance and the psychodynamics between the analyst and the interviewee. In historical research, the aim is narration, but in psychoanalysis, that which is not related may be of the most importance. In health social work practice, the social worker may note what is not related but would hardly speculate too much about possible unconscious motives. In psychoanalysis, the dynamics of transference is a key tool, whereas in health social work practice, although transference may be recognised, it is seldom actively used as a tool.

In comparing the biographical-narrative interview as a technique with the psychodynamic approach, mental health social worker and researcher Charlotta Hallén (2006) found that both aim to help people understand their lives and make conscious behavioural changes, but that the psychodynamic approach entails more interpretation. Both approaches require a trustful relationship and voluntary participation on the part of the client, as well as the capability to reflect on their life situation. Not everyone is able to work in a psychodynamic way, of course, but most clients can tell a life story; a biographical approach may also be possible in clinical settings where a psychodynamic approach is not. Most professional social workers can conduct biographical-narrative interviewing, whereas being able to provide psychodynamic psychotherapy requires several years of training, at least in Finland. Further, the psychodynamic approach usually implies frequent sessions over a long period of time, whereas biographical-narrative interviewing can be used as a tool alongside other tools. Hallén (2006) found biographical-narrative interviews particularly suitable for social work clients.

7.3 Person-centred and existential approaches

In person-centred practice, developed by Carl Rogers (1961), who had a background in humanistic psychology, the biographical perspective shares the view of the individual as a unique subject, an expert on their own life as lived and experienced, with the capacity to change it in the future (cf. Barker 2009). However, in person-centred counselling, the focus is sharply on the immediate present rather than on the history of problems, and it is a principle that the counsellor does not offer any superior knowledge or understanding that the client cannot access. Even so, Barker (2009) maintains that a biographical interview can successfully be offered as an option in person-centred counselling practice if it is explained that the findings will be used as hypotheses for further mutual exploration, rather than considered truths about the person. The biographical approach can also help remind client and counsellor of the fact that the individual's capacity for complete self-actualisation is limited.

At times of loss or turning points, questions about the meaning of life can become significant. In existential social work, the focus is not on a specific therapeutic approach, but on the uniqueness of the clients in their social world. The main areas of existential theory are the worker/client relationship, the nature of personality, the concept of change, the use of historical data and diagnosis, and the treatment methods. (Cf. Krill 2011; Thompson 2005, 21.) The biographical perspective with its holistic view of life seems quite compatible with the existentialist perspective in social work.

7.4 Cognitive-behavioural and problem-solving approaches

Cognitive-behavioural approaches, building on social learning theory and aiming to change dysfunctional thoughts and behaviour, are hardly interested in a client's past. A biographical-narrative interview and life story work would generally be seen as completely irrelevant (cf. Barker 2009).

Problem-solving approaches in social work practice are, by definition, time-limited and for different reasons not very compatible with a biographical perspective in terms

of seeing the past or a story of the past as relevant. Two problem-solving approaches are task-centred practice and crisis intervention (cf. Healy 2014). Task-centred practice (Reid & Epstein 1972) in different forms is presumably quite common in social work practice, in which service users present themselves with a specific problem or social workers are responsible for assessing and informing users of their eligibility for specific welfare services, depending on their situation. A few target problems are defined, generally pertaining to ‘problems in living’ relating to, for example, outcome, housing or employment, and sometimes to social isolation, family conflicts and reactive emotional distress. The work is structured so that it focuses on solving these problems in a limited time, and aims to develop the clients’ knowledge and skills (cf. Healy 2014).

The focus of task-centred practice is generally on the immediate present and has little interest in personal history other than for understanding any historical factors that may directly impact on the problem-solving work. It has even been stated that ‘accumulating substantial past history is inefficient and may mislead the client about the intentions of the practitioner’ (Epstein & Brown 2002, 102–103, cited in Healy 2014, 143). However, it seems that in a multi-theoretical approach, it might be possible, if relevant, to use biographical interviewing as a distinct tool to collect background information and elicit the client’s view on their life situation before identifying the specific target problems and tasks, provided that the point of using this type of interviewing is clearly explained to and agreed on by the client.

Crisis intervention as a problem-solving approach differs in some respects from task-centred practice. It considers crises as both inevitable parts of the life course, for example, at transitions from one life phase to another, and arising through hazardous events such as serious illness or sudden unemployment. Like task-centred practice, crisis intervention is also time limited and structured, but it differs from the former in that it views the expression of feelings as important, and crisis as an opportunity for psychological growth. (Cf. Healy 2014.) The process of biographical work when a severe chronic illness emerges, as described by Corbin and Strauss (1988, cited in Betts et al. 2009, 27–30), somewhat resembles the process described in crisis theory. On the other hand, biographical research stresses that biographical-narrative interviews can sometimes be traumatising for people in acute crisis. In such situations, other narrative ways of giving support may work better (Rosenthal 2003).

7.5 Systems perspectives

The general systems theory, based on biology, was developed for social work in the 1960s. Rather than concentrating on individual clients and their problems, systems perspectives focus on interactions within and across social systems such as families, groups and communities. For example, an individual's mental health should not be seen as resulting from individual psychopathology but should be understood in relation to the exchange between the individual and their cultural environment (cf. Healy 2014, 117). This is in accord with the biographical perspective, which sees the individual as part of a system and stresses the interplay between the individual and society. However, general systems theorists did not necessarily see the past as relevant; they requested psychotherapists to stop 'digging up the past' (von Bertalanffy 1968, 219, cited in Healy 2014, 117) and concentrate on achieving insight into current conflicts instead.

The ecosystems perspectives, which emerged in the 1970s with the second wave of systems theories, used ecology as a metaphor for focusing on transactions within and between systems. One application of the ecosystems perspectives is the Life Model of social work practice formulated by Alex Gitterman and Carel Germain (Gitterman 2011). This model sees people as interdependent on each other and their environment, and that problems arise because of a poor fit between a person's life situation and their environment. The aim of social work is to increase the fit between people and their environment through an active adaptation process; thus it is a model for both assessment and intervention. In the initial phase, the social worker and the client establish an active partnership. This resembles the building of a trustful relationship, also considered necessary for biographical methods.

In the Life Model, clients are seen as bringing their experiential knowledge and life stories to the encounter. The social worker and the client identify strengths and capacities as well as the life stressors in the client's life; a life stressor is an event or transition that contributes to maladaptation in the 'person:environment' fit. The model works from a life course perspective where the aim is to alleviate the life stressors. The model defines three interrelated life issues: difficult life transitions and traumatic life events; environmental pressures; and dysfunctional interpersonal processes. Worker and client together determine practice focus, which, depending on the source of the

life stressor, can be on changing the client's perceptions and behaviours; influencing the social and physical environments; or improving the quality of their exchanges. The social worker's role is to promote change at different system levels: individuals, families, groups, communities, organizations and politics. (Gitterman 2011.) The Life Model can be related to the idea of social workers encouraging their clients to see themselves as biographical actors who can reconstruct their own biography and change social conditions (cf. Roer 2009). The emphasis on the relation between person and environment complies well with the interplay between agency and structure, which is important in the biographical perspective.

In the 1980s, the third wave of systems theories introduced the idea of complex and chaos theories, with their important characteristic of nonlinearity: a change in one variable can be associated with a disproportionate change in another. Whereas general systems theorists argue that social systems are stable and seek balance – homeostasis – complex systems theorists argue that, due to feedback mechanisms, the complexity of complex systems increases over time. (Cf. Healy 2014, 127-129.) From a biography perspective, I refer here to Riemann's and Schütze's (1991) concept of the trajectory of suffering, in which negative feedback reinforces itself and causes the situation to deteriorate uncontrollably. In complex systems, small changes can contribute to substantial and complex changes – the butterfly effect. In social work practice, this could imply that a short-term, well-timed intervention could have an unexpectedly large impact on a client's situation. (Cf. Healy 2014, 129.) A positive butterfly effect could compare with the biographical process structure called creative metamorphosis of biographical identity (Schütze 2009a, 168), which expresses a sudden, often unexpected, major change for the better.

In systemic family therapy, the observer is part of the system; the therapist does not merely observe the system from the outside but is part of the family system and affects it (Boscolo et al. 1987, cited in Fagerström & Karvinen-Niinikoski 2013, 20). In social work practice, this would imply that, for example, biographical information cannot be elicited without simultaneously affecting the system, that is, producing an intervention. The compatibility of the biographical perspective with the systems theories in social work practice seems to depend on which system is meant. If the system is a family in therapy, the past of individual members of the family would hardly be seen as relevant (cf. Kinanen 1968). If the system implies the interplay between the individual and their social world, as in the ecosystems perspective, the biographical perspective seems more compatible.

The ecosocial social work perspective emphasises the profession's responsibility to holistically address the individual as part of nature and to work for sustainable development for all, not for a system built on economic growth (cf. Matthies & Närhi 2014). The systemic environmental perspective here approaches a structural perspective. The interdependence of structure and agency, the interplay between individuals and systems, and the importance of the relationship between the client/family and the therapist fits well with the biographical perspective. However, the temporal dimension does not seem to play an important role here.

7.6 Strengths and solution-focused perspectives

The strengths perspective (Saleebey 2013) and solution-focused brief therapy (Berg 1992) share a focus on clients' strengths and capacities rather than on their deficits and problems. They also share a focus on the future. The main difference between the two approaches is that the strengths perspective focuses more on exploring resources and solutions in the environment and is used in community development as well as in work with individuals, whereas solution-focused approaches are merely used in working with individuals. (Cf. Healy 2014, 164). Len Spearman (2005) views the strengths theory as a perspective connected with a developmental approach and finds it particularly suited for people with mental illness.

Like the strengths perspective and solution-focused approaches, the biographical perspective focuses on the individual's resources for building their future. A person's strengths and resources can be studied through a biographical interview (see Sub-study V). The idea of clients as biographical actors who, when they become aware of their own resources, are able to work out a realistic life plan for themselves (cf. Roer 2009), resembles that of the strengths perspective. In the solution-focused approach, the idea is to find the exceptions in which the problem is not present. The worker takes a 'not knowing' position and remains curious about people's stories and views, strengths and potential. (Cf. Payne 2005, 174–175.) This position is similar to the ethnographic position and the respect for the unknown encouraged in biographical approaches (cf. Riemann 2005; Roer 2009).

The strengths and solutions-focused perspectives have been criticised as being naive regarding the structural obstacles to change, and for being even potentially dangerous in certain practice contexts. The strengths perspective is also criticised for unclearly describing which attitudes and behaviours are determined as strengths. (Cf. Healy 2014, 179–180.) In biographical thinking, the concept of social constraints expresses the notion that there are limits to what a biographical actor can achieve. In identifying resources and strengths, the strengths perspective seems quite compatible with the idea of supporting clients' biographical agency.

7.7 Structural social work, anti-oppressive approaches, empowerment

Structural social work (Mullaly 2007), anti-oppressive approaches (Dalrymple & Burke 2006) and empowerment approaches (Fook 2012) share the belief that structures can be changed. The biographical perspective sees social workers and clients as biographical actors in a society in which social conditions can and should be changed (cf. Roer 2009). By providing knowledge about and advocating the biographical needs of different client groups, social workers can work on a structural level as well as on an individual level.

In describing anti-oppressive practice, Jane Dalrymple and Beverley Burke (2006, 117; 163; 286) maintain that exploring biography is an important factor for understanding why clients' personal experiences lead to feelings of powerlessness. However, their concept of biography in this context seems to be more related to the individual's inner life (feelings) and life experiences than to social relationships. Interestingly, some scholars encourage anti-oppressive social workers to reflect on how their own biography and social context shape their practice (cf. Burke & Harrison 2002, cited in Healy 2014, 196).

Empowerment aims to help clients 'gain power of decision and action over their own lives' (Payne 2005, 295). This is done by reducing the effect of social or personal obstacles to exercising the power they possess. In discussing the political role of empowerment in social work, Stuart Rees (1991, cited in Payne 2005, 303) identifies biography as one essential practice idea, useful for analysing clients' experience and understanding

about the world, and for helping identify what prevents them from acting. This idea of using biography for empowering social work seems compatible with my definition of biographically informed health social work practice. Although the empowering effect of self-awareness is not automatic (cf. Bornat & Walmsley 2004), biographical methods can give marginalised and vulnerable people a voice (cf. Chamberlayne 2004). Jan Fook (2012, 124–130) discusses empowerment in relation to social workers themselves, emphasising that social workers should also see themselves as biographical actors, capable of acting and taking professional responsibility (cf. Roer 2009, 194).

7.8 Theoretical compatibility

This chapter has discussed how the biographical perspective relates to different theories that are relevant for social work practice. Biographical research uses both realist and constructionist stances, and in health social work practice, both stances are often needed. Earlier chapters found the life course, narrative, reconstructive and relationship-based approaches to be, by definition, compatible with the biographical perspective in social work practice. Biographically informed social work seems to be compatible to some degree with most other common social work practice theories, except for the behavioural and the problem-solving approaches. The best compatibility appears to be with psychodynamic approaches, the strengths perspective and empowerment. Person-centred practice, existential social work and systems perspectives also seem to fit fairly well. In multitheoretical social work practice, it seems possible to combine the biographical perspective with different social work approaches for different purposes in different phases of the social work process.

8 Discussion and conclusions

When I started my research, literature on how to relate to clients' life story-telling in general social work practice was largely lacking. Life course, life story and reconstructive approaches had been described, but they seemed to demand a more structured approach. With the presumption that health social workers, whether aware of it or not, often make theoretical assumptions by drawing on patients' past lives, this summary article, using a conceptual method and based on six sub-studies and additional literature, aimed to explore how social workers can more explicitly take the lived and told lives of patients into account in biographically critical situations. Two research questions were formulated: one concerned the content and implementation of a biographical perspective, and the other the compatibility of such a perspective with social work practice theory. As a result of my research, I formulated an explicit, general and heuristic definition of biographically informed health social work practice, which I found to be fairly compatible with several social work practice theories.

Biographically informed social work practice identifies two aspects: the general biographical perspective as a lens and biographical approaches as an intervention. The biographical perspective implies viewing clients as biographical actors in their social world and regards the task of social workers as being to support clients' biographical agency. The main biographical intervention is the biographical interview, which should be used with discretion, only when relevant. Sometimes clients want to tell social workers about their life without being asked: this may be a sign that the client wants to do biographical work, that is, reflect on their life and develop more self-understanding as a basis for biographical action. Even though the biographical interview may have therapeutic effects, it is mainly appropriate for assessment. Other methods may have to be used for social work intervention.

My research suggests that biographically informed social work practice may work well in general health care settings, which are often rather hectic and fast paced, and do not always allow for consistent long-term social work approaches. Extensive biographical interviewing is, of course, not appropriate for all service users, in all situations and in all health care organisations. However, the biographical lens, in the form of holistically viewing clients as unique biographical actors, seems appropriate in most situations. A strong, trustful worker/user relationship is also essential; here one could argue for a relationistic meta-theory, which sees clients as partners in collaborative care.

As a strength of my study I see the fact that it is the result of a lengthy process beginning in social work practice and gradually growing into a deeper theoretical

understanding of how a biographical lens can be used in practice, providing a holistic view of clients and the work. My study draws on both empirical and conceptual studies. As a weakness, I acknowledge the scarce empirical evidence. As a weakness, I acknowledge the scarce empirical evidence but conceptual evidence supports my conclusions.

My search for comparable studies on the explicit use of the concepts of biographical or life course agency in professional practice has resulted in very little. The idea of supporting clients' strengths and resources in social work practice is not new. Other concepts such as life control, coping, self-regulation, mastery, self-efficacy, and empowerment are often used to express clients' agency in professional practice (cf. Fook 2012; Järvikoski 1994; Suominen 1993). However, discussions on how clients' biographical accounts could be dealt with seem rarer in this context. Biographical scholar C. Dorothee Roer (2009) does talk about viewing social work clients as biographical actors without explicitly using the term biographical agency. Betts and colleagues' (2009) article on reconstructive biographical counselling in vocational rehabilitation mentions the biographical action scheme as a process structure to be looked for in clients' biographies. Discussing life course agency in relation to career counselling, Marjatta Vanhalakka-Ruoho (2014) emphasises the existential perspective.

My research argues that a discussion on biographically informed social work practice could provide practitioners with a new paradigmatic orientation and theoretical framework to strengthen the profile of health social work in an interdisciplinary environment and society at large, and promote research-based practice. In a fragmented social welfare and health care service system, the biographical lens could help social workers and other professionals maintain a holistic view of the needs of the unique biographical actor – the client they have been assigned to serve.

Biographically informed social work practice, as presented here, will perhaps be criticised for being too individualistic, but this is a conscious choice. My focus has been on advancing social work practice methodology for the work with individuals. On the other hand, social conditions and problems can gain attention through the biographies of individual clients. By advocating individual clients' rights in society, health social workers can provide legislators with feedback on how regulations and laws affect service users at the grass-roots level. With biographical knowledge of individual clients, social workers can engage in activities of social change and transformation.

In the future, it would be important to further empirically study the benefits and possible risks of working with clients' biographies by looking at different client groups in different situations. The question of how biographies are elicited, interpreted, used and documented is crucial and needs further investigation. In particular, empirical studies of clients' own experiences of and views on biographical approaches in health social work practice would be important. More studies on different aspects of the biographical lens and biographical approaches could provide significant knowledge for health social workers interested in developing their biographically informed practice. And why not for social workers in other fields as well?

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Appendix

Table 1

Summary of six sub-studies

Title	Research question(s)	Data and analysis	Main concepts	Results
<p>I (2007) Knowledge and Social Work in Health Care – The Case of Finland</p>	<p>1) How is professional competence in health social work acquired and maintained? 2) How is knowledge and research perceived by health social workers? 3) Do health social workers differ in this respect from social workers working in other settings (the municipal social services)?</p>	<p>Survey results from 110 social workers in health care were compared to 295 social workers in the municipal social services. Frequencies, cross-tabulation, Chi-square test for independence. One focus group interview with seven social workers in health care analysed by content analysis.</p>	<p>Knowledge, research, professional competence, expertise</p>	<p>1) Professional competence is acquired through social work education and maintained through further education, supervision. 2) Social workers in health care want new knowledge for their work and are interested in research. 3) Compared to social workers in municipal social services, many health social workers work more autonomously.</p>
<p>II (2009) Social Constraints and the Free Will – Life Course and Vocational Career</p>	<p>1) How is free will related to social constraints? 2) How is vocational career related to the life course?</p>	<p>Literature. Conceptual-analytical.</p>	<p>Life course, social constraints, free will, mastery, SDOH, ACE. - Vocational career from a life course perspective.</p>	<p>1) There is an interplay between social constraints and free will, and this interplay can be captured through a biographical perspective. 2) Vocational careers change over the life course: education -> working life -> retirement.</p>
<p>III (2009) Biography, Narrative and Rehabilitation</p>	<p>1) What are some of the basic concepts in the discussion on biographies and narratives? 2) How can biographies be used in rehabilitation?</p>	<p>Literature. Conceptual-analytical.</p>	<p>Biography, narrative, rehabilitation - A narrative approach to rehabilitation.</p>	<p>1) Biography was earlier seen as accounts of lived lives; the life story itself has now also become the subject of analysis. 2) Biographies and narratives can be useful in rehabilitation viewed as helping people carry out their life projects and manage their lives.</p>

<p>IV (2009) Social Work Case Analysis of Biographical Processes</p>	<p>How can biographies and narratives be analysed and used in social work?</p>	<p>Literature. Conceptual-analytical.</p>	<p>Biographical action scheme; institutional expectation pattern; trajectory of suffering; biographical metamorphosis; biographical identity; biographical work.</p>	<p>Biographies can be analysed in different ways and used in different fields of social work, particularly in health social work practice.</p>
<p>V (2014) A Social Work Perspective on the Biographical Research Interview with Natalia</p>	<p>If the narrator was telling her story to a social worker, how might the worker listen and analyse the story? In what way would this differ from a researcher's way of listening and analysing?</p>	<p>One transcribed biographical research interview performed by a Polish biographical researcher. Biography case analysis using content analysis and strengths-based social work theory.</p>	<p>Setting of biographical interviewing; strengths-based social work.</p>	<p>A biographical interview in social work practice can be analysed using the strengths-based social work theory. Social work practice and research differ considerably as a setting for biographical interviewing and analysis.</p>
<p>VI (2016) Does past life matter? Social workers' views on biographical approaches</p>	<p>How do social work practitioners view the use of biographical approaches? a) What is the 'biographical working tool'? b) How can biographical approaches enhance practice? c) What are the particular challenges of biographical approaches?</p>	<p>The final essays of 16 respondents attending a Master-level course on biographical approaches in social work. Content analysis with an abductive approach.</p>	<p>Biographical approach to social work; life story; 'biographical lenses'; user reflection; social worker listening.</p>	<p>a) The 'biographical tool' is defined. b) Biographical approaches enhance social work practice by providing a space for user reflection and social worker listening, and by promoting the understanding of clients' life situations. c) Challenges are posed by the user-worker relationship, ethical questions, and the prerequisites for conducting biographical-narrative interviews.</p>

Sub-studies

I Knowledge and Social Work in Health Care - The Case of Finland¹

Johanna Björkenheim

ABSTRACT

Studies carried out in different countries have shown that there is a lack of a common and up-dated knowledge base in social work, and that social workers make use of research in their everyday practice only to a very limited extent. On the other hand it has been shown that social workers feel they need knowledge but not necessarily in the form it is produced by the researchers.

This paper explores issues of knowledge and competence in health social work based on the results of a survey and a focus group interview conducted among social workers in Finland. According to the results, social workers in health care do feel they need new knowledge. Some significant differences were found in the way health social workers view the acquisition and maintenance of professional competence and in the way they seek knowledge, when compared to social workers working in the municipal social services.

Keywords: Knowledge, knowledge seeking, professional competence, social work in health care

1 INTRODUCTION

This paper explores issues of knowledge and competence in health social work in Finland based mainly on the results of a survey conducted among social workers in different parts of the country and in different work settings. Knowledge building and competence in social work have become burning questions in Finland, where the social work education and the societal context for social work has changed rapidly during the last decades. Social work becoming an academic profession and being established

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as a discipline of its own at the university has produced quite a lot of new research in social work, but this research does not seem to have affected practice very much. The government is now running a reorganisation of the social services with the aim of developing knowledge-based good practices. This work is supported by a country-wide network of eleven government-funded centres of expertise and excellence in the field of social welfare with the task of enhancing collaboration between research, education, and the practice field, and of promoting and ensuring basic and specialist expertise in social welfare, including social work.

So far social work in health care has received little attention in this process of developing the social work practices. Practically all health social workers in Finland work in the public health sector, which comprises both generalist care and specialist care, from local health centres to regional university hospitals. Public health care services are generally, like in the other Scandinavian countries, provided for people from all socioeconomic backgrounds as part of the universalistic welfare state model. However, after the economic depression at the beginning of the 1990s the public health sector is having increasing financial difficulties, and cuts have been made in health care like in other welfare services. There are even signals indicating a change towards a more selective service system.

In this new situation social work in health care is facing big challenges due to factors such as an aging population, a shift in the service structure from institutional to home care, a shift in the service production from publicly produced services to more private and other types of services (welfare-mix), an increasing need to involve volunteers and families as resources, a growing demand for evaluation of social services and social work, and legal and ethical issues in the frame of the new public management. Financial cuts, increasing demands for effectiveness, and new professions claiming competence in the social field add to the need for redefining the role of social work in health care. (This issue has been discussed e.g. by Heinonen et al 2001.) In this process of redefinition issues of knowledge, competence and research will have to be discussed and considered.

2 THE USE OF KNOWLEDGE IN SOCIAL WORK PRACTICE

Knowledge in social work practice has been discussed for many years and from different perspectives. Social work has been said to lack a common and up-dated knowledge base (e.g. Bergmark & Lundström 2002), although in health care attempts have been made to define a knowledge base for social work (e.g. Ma 1997). Knowledge has been debated in terms of differences in communication between practitioners and the academic world (Osmond & O'Connor 2004), and it has been defined and categorized in different ways (Rosen 1994; Lyons 2000; Tynjälä 2004). Often when talking about knowledge what is meant is so-called evidence-based knowledge. Nonaka et al (2000) define knowledge in a broader way as “a dynamic human process of justifying personal belief toward the ‘truth’”, as being created in social interaction, and as being context-specific, related to human action, and relational. They see knowledge as being created through interactions between tacit and explicit knowledge.

The Swedish researchers Bergmark and Lundström (2002) found that only a minority of the social workers working in the individual and family care of local government administrations actively seek new knowledge in their field. The authors lay the responsibility for this on social work education, on researchers, on employing organisations, and on the social workers themselves. In the U.S. researchers have found that compared to other professions, in particular to psychiatrists and psychologists, social workers make use of research or research-related literature in their everyday practice only to a very limited extent (Mullen & Bacon 2003). In Great Britain knowledge and practice in social work have been criticized for being deficient and lacking in competence, particularly in the field of childcare (e.g. Vass 1996). The Swedish researchers Nordlander & Blom (2002), however, showed that social workers do not dislike evidence-based knowledge but tend to find it less useful than e.g. novels, when it comes to understanding the existential problems of the clients. Social workers were found often to acquire knowledge from colleagues, internal courses, and fiction rather than from scientific journals. This was attributed to insufficient searching skills in looking for evidence-based knowledge, and to lack of time to read and reflect upon new knowledge.

Most studies performed on social workers' attitudes towards knowledge and research concern social workers working in the public (municipal) social services. This is true at least for the two Swedish studies mentioned above, where the context is similar to that of Finland. This paper aims at studying issues of knowledge from the

point of view of social work in health care, although it does not directly compare the results with those of the Swedish studies. In this article the term 'knowledge' is used in a broad sense without any precise definition. The social workers participating in the study have been free to understand 'knowledge' in their own way.

The results presented are preliminary but give us some ideas about trends and challenges in health social work of today. The results discussed in this article serve as a basis for further analysis of data, which will provide more knowledge on the characteristics of and the expertise in health social work.

3 AIM AND METHODS OF THE STUDY

The aim of this paper is to study health social workers' views on the use of knowledge for their work by addressing three questions:

- (1) How is professional competence in health social work acquired and maintained?
- (2) How is knowledge and research perceived by health social workers?
- (3) Do health social workers differ in this respect from social workers working in other settings (the municipal social services)?

Data was collected mainly through a survey. The study is part of a larger research project, which examines the mechanisms, structures and practices in professional knowledge production, innovations and the development of expertise in social work in Finland (Karvinen-Niinikoski et al, in prep.), and the survey data was drawn from a larger survey conducted within this research project. A questionnaire was sent out in October 2003, and a reminder a month later, to a total of 1,582 social workers, all members of the largest trade union for social workers in Finland. Answers were received from 716 social workers, i.e. 45.3%. The sample consisted of one third of the Finnish-speaking members and all the Swedish-speaking members of the union. Finland is a bilingual country, and union members are registered by mother tongue. Because the survey results of the Swedish-speaking social workers are to be analysed separately and since this group is small - only 333 union member social workers - the questionnaire was sent out to all the members of this group. The response rate was the same in both language groups. The final data was weighed accounting for language and consists of answers from 583 social workers, 110 of which work in the public health sector.

In order to see, whether social workers working in the health sector differ in their attitudes to knowledge compared to social workers in other work settings the survey results of the health social workers (N=110) have been compared to those of the social workers working in the municipal social services (N=295), which is the largest employer of social workers in Finland.

The questionnaire used contained a large amount of questions, a number of which, dealing specifically with knowledge and research, were analysed for this article. The data was analysed using frequencies and crosstabulation, and, where possible, significance was tested using the Chi-square test for independence; due to low expected count in some cells this was not always possible. In addition, data from a focus group interview conducted with seven health social workers from one social work department in a university hospital in September 2002 have been used for reflection of the survey results.

4 BACKGROUND DATA OF SURVEY RESPONDENTS

Background data of the survey respondents (table 1) show that social workers in health care are significantly older than their colleagues in the municipal social services. About 70% of the respondents in health care were over 45 years old compared to 53% of the respondents in the municipal social services. A large majority of all respondents were women, as in the profession in general.

Social work education in Finland has been at a Master's level for about 20 years, but due to certain criteria for competency many social workers do not have a Master's degree. This is particularly true in health care, where social work started out with nurses being educated to 'social nurses', some of whom are still in work. The difference in education level compared to social workers in the municipal social services is significant, although the proportion of persons with formal competency is about the same. The professional education can be expected to have implications for how social workers view knowledge.

Social workers in health care have generally been working in social work longer than their colleagues in the municipal social services, which is in consistence with the fact that they are older. Almost 70% of the respondents in health care had been in the profession for more than 15 years compared to less than half of the social workers in

the municipal social services. One third had held their present job for more than 15 years. A long working career can be expected to have an impact on how theoretical knowledge is valued in relation to experiential knowledge.

TABLE 1. Background data of social workers in health care compared to social workers in the municipal social services (%).		
	Social workers in health care %(N=110)	Social workers in social services %(N=295)
AGE*		
Under 34 yrs	9.1	20.3
35-44 yrs	20.9	26.8
45-54 yrs	45.5	33.6
Over 55 yrs	24.5	19.3
Mean age	47.9 yrs	44.2 yrs
Median age	48.5 yrs	46.0 yrs
Age range	25-62 yrs	23-62 yrs
SEX		
Female	94.5	93.6
EDUCATION*		
M.Soc.Sc. in Social Work	22.7	29.2
Master's degree in other subject	10.9	13.6
University Diploma in Social Services 1)	36.4	20.3
B.Soc.Sc. in Social Work and Social Policy	10.0	10.8
FORMAL COMPETENCY	85.3	83.7
WORK AND WORK HISTORY		
In present job for more than 15 years	34.3	25.8
In social work for more than 15 years***	69.3	45.2
1) Corresponding to a BSW exam. * p<=0.05, *** p<=0.001 (Qui-square test for independence)		

5 ACQUISITION AND MAINTENANCE OF PROFESSIONAL COMPETENCE

The social workers' views on how they had acquired and how they maintained their professional competence was studied by looking at the survey results on questions dealing with four perspectives: the most important factors in building up professional competence, knowledge creating with co-workers and social work colleagues, learning from work, and the use of supervision. The term 'professional competence' was not specified; the respondents could give the term whatever meaning they chose to.

5.1 Most important factors in building up present professional competence

When it comes to rating the four most important factors in building up professional competence, there is no difference of opinion between the social workers in the two different work settings (see table 2). Even the order of importance is the same: work experience is regarded as the most important factor followed by life experience, social work education, and further education. However, the survey also showed some differences. Social workers in health care seem to rely more on in-service training and supervision (supervision in the form it is provided in Finland; see below 5.4) than their colleagues in the municipal social services, who instead rely more on feedback and support given by the managers.

About one third of the social workers in both groups were taking some kind of study course at the time of the survey. When asked about the reasons for not having taken part in any further education during the past two years, the health social workers mentioned lack of interesting educations and lack of time, while their colleagues in the social services mentioned lack of time and being too tired.

The impact of life experience on professional competence was articulated by the participants in the focus group interview as adding to their humanity and humbleness, as being able to view clients more as human beings than as clients, and as realising that as social workers they do not know everything. Professional competence was considered to include as important elements taking time for listening to and processing with the client, giving the client space and options, and not pushing him or her in a certain direction.

TABLE 2. Most important factors in building up professional competence as viewed by social workers in health care compared to the view of social workers in the municipal social services (%).

Question: How important have the following factors been in building up your present professional competence? Answering alternatives: Of great importance - of some importance - of no importance		
OF GREAT IMPORTANCE	Social workers in health care %(N=110)	Social workers in municipal social services %(N=295)
Work experience	93.8	93.2
Life experience	73.6	62.6
Skills learned from co-workers/colleagues	34.6	35.4
Skills learned from managers	10.0	19.8
Social work education	54.6	50.7
Further education	50.4	40.7
Feedback and support from co-workers/ colleagues	33.3	40.3
Feedback and support from managers*	17.1	29.9
Independent studies	48.4	32.9
In-service training*	30.0	18.2
Professional literature (magazines, re- search etc.)	29.7	20.2
Supervision***	38.6	18.8
Consultations with experts	40.8	29.5
Art and culture (films, fiction etc.)	8.7	6.3
Other, what?	12.5	24.4

* p<=0.05, *** p<=0.001 (Qui-square test for independence) Due to low expected count in some cells the Chi-square test could not be used to test the significance for other variables with great differences in outcome.

5.2 Knowledge building with co-workers and social work colleagues

Social workers working in the same work agency presumably meet more or less often during the day, not just for formal meetings but informally as well. They have many opportunities for dialogues on work-related issues promoting and stimulating knowledge building. This possibility is lacking in work agencies where there is only one social worker, or where the social workers are scattered into different units and mostly working with other professionals, as is often the case in health care. On the other hand, working with colleagues of other professions offers many chances for learning and for knowledge building of a different kind. Some of the questions in

the questionnaire aimed at capturing the respondents' views on the importance of knowledge building with co-workers and social work colleagues as opposed to working in a very routine way (table 3).

The social workers generally seemed to think that discussing with colleagues and co-workers helps them in solving problems, and they are themselves prepared to share with others what they know. The social workers in health care, however, seem to have informal discussions about problems in their work much less often than their colleagues in the municipal social services, which suggests that they have to work more independently. Social workers in health care also spend significantly more time finding and providing others with knowledge than do the social workers in the municipal social services. This may have to do with the fact that social workers in health care serve as experts in their own field for professionals in other fields.

TABLE 3. The importance of collaborate knowledge building with colleagues/co-workers as perceived by social workers in health care compared to social workers in the municipal social services (%).		
AGREE TOTALLY OR PARTIALLY 1) with the following statements:	Social workers in health care % (N=110)	Social workers in social services % (N=295)
By discussing with my colleagues/co-workers I can solve more difficult problems than I could otherwise.	90.0	91.7
I am ready to teach my colleagues/co-workers everything I know.	88.9	93.5
We usually tell each other how we have managed to solve a complicated situation.	82.4	79.0
My colleagues/co-workers and I often have informal discussions about problems in our work.***	68.2	84.6
A great part of my work consists of finding knowledge for the use of others.***	72.0	28.8
1) Answering alternatives: Agree totally/partially - disagree totally/partially. *** p<=0.001 (Qui-square test for independence)		

5.3 Learning from work

Most social workers in both groups said they encountered new situations and problems in their work all the time. (Table 4.) This can of course be both challenging and tiresome. However, most social workers felt they continuously learned new things in their work, and this was generally seen as a positive challenge. Sometimes the

demands of knowing, learning and developing can become too much, but this seems to happen less often in health care than in the municipal social services, where to a significantly higher degree the social workers felt that they did not have the time to get informed enough to do a good job, nor that they had time to develop their practice.

TABLE 4. Work as a learning experience in the view of social workers in health care compared to social workers in the municipal social services (%).		
AGREE TOTALLY OR PARTIALLY 1) with the following statements:	Social workers in health care % (N=110)	Social workers in social services % (N=295)
In my job I encounter new situations and problems all the time.	94.5	95.9
I continuously learn new things in my job.	89.0	86.2
Situations where I can learn and see things in a new way are challenging.	89.9	93.5
I do not have time to get informed enough about the problems I have to solve at work.***	37.0	68.3
There is no time to develop my practice.***	50.9	71.7
1) Answering alternatives: Agree totally/partially - disagree totally/partially *** p<=0.001 (Qui-square test for independence)		

5.4 Supervision

In Finland the word for supervision - ‘työnohjaus’ in Finnish, ‘handledning’ in Swedish - generally has a different meaning than the term ‘supervision’ in the Anglosaxon world. ‘Työnohjaus’/‘handledning’ is by definition usually provided by a person not connected to the workplace, i.e. not by the line manager but by a professional, who has been accredited as a supervisor. ‘Työnohjaus’/‘handledning’ is more oriented towards reflection, dialogue, support and professional growth than towards consultation, direct advice and management. It can be provided on an individual basis, or to a group of social workers, to a multiprofessional team or other.

61.8% of the health social workers responding to the survey had participated in this type of supervision during the previous 12 months. Supervision received in a group was significantly less common in health care than in the municipal social services. This may reflect the fact that social workers in health care more often work alone and therefore receive supervision individually. Supervision for multiprofessional teams is still quite rare. It is interesting to notice that, although the proportion of social workers having received supervision was about the same in both groups, the social workers

in health care found supervision significantly more important in building up their professional competence than did their colleagues in the municipal social services (as shown in table 2).

6 VIEWS ON KNOWLEDGE AND RESEARCH

6.1 What is knowledge?

What is relevant knowledge in social work? As already mentioned, the social workers participating in the survey were free to conceptualise knowledge in whatever way they wished. This was a conscious choice made by the research group. Since the social workers were not asked to specify what they meant by the term, it is not possible to know exactly what their conceptualisations have actually been in answering the survey. The health social workers participating in the focus group interview articulated some thoughts on their perceptions of knowledge. They defined 'knowledge' in the following ways: Knowledge is what social workers learn through education. Knowledge is knowing how society functions and what the societal conditions are for individuals and families. Knowledge means social work theory, concepts, terminology, social work methods, and legislation. Knowledge is knowing how to interact with clients, how to approach individual clients differently, how to make tailored solutions with them. It is also knowing what you do not know, knowing how to process, how to get informed, and knowing that you have to limit what you do and how you can do it. Knowledge is knowing how to use knowledge in flexible ways. It is knowing something other professionals do not know.

6.2 Ways of seeking knowledge

Knowledge building can be facilitated or hindered by the organizational structures of the workplace. In the survey the social workers were asked how they go about to get a particular piece of knowledge that they need in their work (table 5).

The most common ways of seeking information in health social work seem to be to contact authorities supposed to know, to search on the internet, and to ask colleagues/co-workers. Professional literature or magazines are not uncommon sources of information either. Asking the manager is significantly less common among the health

social workers than among their colleagues in the municipal social services. It seems that searching for relevant knowledge often happens through some kind of personal interaction with colleagues, authorities etc., although the internet and professional literature have become important tools as well. A majority of the social workers nowadays have access to internet as a source of information.

TABLE 5. Health care social workers' ways of seeking knowledge compared to social workers in the municipal social services (%).		
Question: If you need a specific piece of knowledge, how do you go about to get it? Answering alternatives: Often - quite often - sometimes - seldom - never.		
OFTEN OR QUITE OFTEN	Social workers in health care %(N=110)	Social workers in social services %(N=295)
I ask the manager***	20.0	42.6
I ask fellow employees	59.6	76.7
I ask social work colleagues outside of my workplace	31.2	25.7
I ask friends and/or relatives	2.7	1.0
I ask clients	7.3	8.9
I ask authorities supposed to know	83.6	57.7
I look for it in professional literature or magazines	54.5	37.9
I search on the internet	62.7	38.2
In some other way	54.5	26.3
Has unlimited access to internet	89.9	97.6
*** p<=0.001 (Qui-square test for independence). Due to low expected count in some cells the Chi-square test could not be used to test the significance for other variables with great differences in outcome.		

6.3 Use of and attitudes towards research

The respondents of the survey were given four statements on research, which they were asked to agree or disagree with on a four-graded scale (table 6). Most social workers seem to think that research helps them in structuring their thoughts and in finding new perspectives. Surprisingly, it is significantly more common for social workers in health care to think that research gives them ideas that they can apply in their work than for their colleagues in the municipal social services. A majority of the health social workers also seem to value collaboration with the university and/or other

educational institutions. In spite of this, most social workers seem to think that it is very important to work in accordance with the rules. This is understandable when it comes to social workers working in the municipal social services exercising power of authority but is maybe more surprising with social workers in health care.

TABLE 6. Health care social workers' use of and attitudes towards research compared to social workers in the municipal social services (%).		
AGREE TOTALLY OR PARTIALLY 1) with the following statements:	Social workers in health care %(N=110)	Social workers in social services %(N=295)
What do you think of the usefulness of research?		
- Research helps me in structuring my thoughts and in finding new perspectives	98.1	95.1
- Research gives me ideas that I can apply in my work*	83.3	72.9
I try first and foremost to work according to the rules.	87.0	84.3
Is collaboration with the university and/or other educational institutions important? - Yes.	86.2	80.3
1) Answering alternatives: Agree totally/partially - disagree totally/partially		
* p<=0.05 (Qui-square test for independence)		

Some elaboration of health social workers' views on research can be found in the results of the focus group interview. The health social workers participating in this interview, on one hand, said there is a lot of knowledge and research they should make more use of, but, on the other hand, they thought that there is not enough research relevant to social work in health care. Some even doubted the usefulness of research at all. A wish for more research based on value discussions was expressed. For instance, the impact of financial cuts in the welfare services on certain client groups was seen as an important objective for research. A need for more research to help them advocate for their clients and client groups in multiprofessional teams, with authorities, and in society was expressed. The social workers thought researchers should be more active in bringing out their research results, because it seemed impossible to be continuously keeping up with new research. They also wished that research reports be shorter and written in a more comprehensible way.

The participants in the focus group interview felt it would be good to do some research themselves, because it would give them a higher status in the university hospital, where research is highly valued. They wanted to do research in order to get "hard facts" that they could present to their colleagues of other professions, and they

also wanted to do research on how to work with clients, so that they could improve their own practice. However, one problem with doing social work research in a multiprofessional setting is that it is hard to distinguish the social work part from the work of other professionals. When doing research within a multiprofessional team, there is also a risk that other professions take the lead. But the social workers felt that doing multiprofessional research could be rewarding as well. What prevented the social workers from doing more research was above all the lack of time and money, insufficient research skills, and the lack of support from the university and from the centres of expertise.

7 CONCLUSIONS AND DISCUSSION

The study shows that, even though the Finnish social workers in health care are older and have a somewhat lower academic education than their colleagues in the municipal social services, they do not lack interest in knowledge and research, whatever their definition of 'knowledge' is. A vast majority of the health social workers participating in the survey expressed a wish for more collaboration with the university and/or other educational institutions, which can well be interpreted as experiencing a need for more knowledge and maybe also a need for a higher academic education.

A majority of the respondents said they are interested in research, because it gives them ideas that they can apply in their work. This seems to imply that they actually acquaint themselves with research results, which contradicts the assumption that because of lower academic education health social workers are less interested in research. However, the respondents do not say that they actually apply the research results, only that they get ideas that they can apply. This could mean that hearing and reading about research results stimulates their thinking about their own work, which affects their practice indirectly, even if not directly. This conclusion is supported by the fact that almost all the respondents answered that research helped them in finding new perspectives.

The fact that a majority of the social workers stated that they first and foremost try to work in accordance with the rules may not exactly be what you expect to hear from an autonomous professional social worker. On the other hand, it may reflect social workers' increasing awareness of patients' and clients' legal rights. On one hand, the Finnish welfare system is quite complicated and currently changing, and social workers

need to keep themselves continuously updated about rules and regulations in order to give clients and colleagues in the multiprofessional teams adequate information about benefits and services available to every individual client. However, the interest in knowledge, which the social workers express, hardly means just an interest in knowledge about the rules. There is, on the other hand, an increasing awareness of the subjective rights of clients.

The social workers in health care spend significantly more time than their colleagues in the municipal social services finding and providing others with knowledge. This fact may reflect the character of health social work as providing specific expertise in the teamwork of multiprofessional settings, but it may also reflect a different attitude towards the clients. In health care an important part of the social worker's job is to provide clients with information and advice and enhance clients' 'knowledge', whereas in the municipal social services the main task probably still is to make possible decisions of authority with less time to inform clients about services other than their own and to process new plans with the clients.

In acquiring and maintaining their professional competence, social workers in health care seem to rely significantly more on supervision and in-service training than do the social workers in the municipal social services, who instead rely more on the support of their managers. This catches the difference of work setting in a nutshell: Social workers in health care work more independently networking, consulting authorities, and searching for knowledge relevant to individual client situations. There is seldom a manager to turn to with questions and for support. In health care the manager of social workers is often physically situated elsewhere or has a different education and is therefore less available or is not able to give advice relevant to social work. Social workers in the municipal social services in the Nordic countries, on the other hand, have a double role, which health social workers do not have: besides the role of helping their clients in finding solutions to problem situations, they are at the same time exercising power of authority. It is evident that they often need to discuss with their manager the decisions they are about to make. This difference most probably explains why supervision and studies are more important to social workers in health care than to the colleagues in the municipal social services. Furthermore, working in a multiprofessional context constitutes a particular challenge for a social worker's professional competence and professional identity, especially if she is the only social worker in her workplace. Supervision and studies offer good opportunities for

meetings with other social workers and for strengthening professional identity. And, besides general social work knowledge, social workers in health care do need some knowledge related to sickness and health, which they can often easily acquire through in-service training.

To be continuously confronted with new situations and problems seems to constitute a main challenge for social workers in general, although it offers many learning opportunities as well. The learning aspect was appreciated by the majority of the social workers in health care, although about half of them seemed to think that they did not have time to apply the new knowledge for developing their practice. Learning, studying research results, and transforming new knowledge into practice takes time. It is difficult to see how social work practices can develop and become more reflective and knowledge-based, if the working conditions do not allow for this to happen.

In the questionnaire there was an open question about the respondent's views on the future. It seems that Finnish health social workers are at the moment rather pessimistic about the future of their profession. They fear that, with the continuing financial constraints, cuts will lead to a diminishing demand for their services. Some of them feel that they are put to do secondary tasks leaving them with less possibility to do the work they are qualified for. The status and salary of health social workers are low, and there is pressure to lower the educational standards. Vacancies are left unfilled or filled with persons with less competence and less education. The social workers feel that other professions are taking over the "social" part in health care.

It seems reasonable to assume that the social workers' interest in research reflects a hope that research could help them do a better job and increase their professional status in the health care setting. The long academic research tradition in health care presumably also contributes to enhancing health social workers' positive attitude to research. Efforts to produce data bases of social work research will hopefully meet social workers' need for easier access to research in the future. However, before research results can be adequately applied into reflexive social work practices, they will have to be processed and assessed by the social workers themselves to fit the work context and the personal way of working. More systematic sharing and processing of new knowledge in study groups with social work colleagues could be an effective way of learning about and implementing research-based knowledge, since the social workers' way of working is through interaction with people, be it clients, colleagues,

other professionals, authorities or other. Such study groups could provide a more structured forum for the kind of collaborate knowledge building that seems to be such an important way for social workers to acquire new knowledge.

In spite of the pessimistic views on the future of their profession many social workers in health care still do find their work challenging and necessary, and show a strong commitment to their work, as the social situation for many of their clients is getting worse. Health care represents a particular type of setting for social work with special demands for independent working skills and a strong identity acting professional expert in a multiprofessional environment. This has implications for both the basic and the further social work education. The new centres of excellence on social welfare could also offer social workers in health care an important arena for exchanging and creating knowledge relevant to the particular needs of social work in a health care setting.

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II Social Constraints and the Free Will – Life Course and Vocational Career¹

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SHORT DESCRIPTION

This module deals with issues of life course and the interrelationship between external, social conditions and the free will in forming identity, with special emphasis on the vocational aspects. The construction of mastery and autonomy is discussed.

LEARNING OBJECTIVES

1. Know some basic concepts in the discussion about social constraints, the free will and mastery.
2. Develop an understanding for the interplay between the social constraints in a person's life and the person's possibilities to shape his or her own life with special emphasis on vocational career.
3. Be able to identify the interplay between social constraints and the free will in an autobiography.

1 INTRODUCTION

In human cultural tradition it has always been common to divide life into different stages and, based on the divisions, to divide people into different groups with different characteristics, and to have different expectations on people depending on which group they belong to. The life stages are constructed as part of the social order, but since they often coincide with biological changes in the individual, there may be an illusion that

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the life stages are part of the natural order, i.e. part of human natural development. What you can and should do at a certain age relates to age but is not a consequence of age. (Tuomi 2001, 13.)

Different metaphors have been used to describe life course, for instance a circle, a bow or a line. Sometimes life course has been described as a tree, a path or a river. Variations of the circle metaphor are a wheel and a van, and of the bow metaphor a bridge, an arch, a staircase, and a rainbow. From the 16th to the 19th century the life stages were often described as stairs rising on the left and descending on the right; in the bow metaphor the different life stages are not seen as equally important. From the 18th century on it has been common to think that society is continuously developing, and this analogy has been applied to the individuals as well. Nowadays, the line metaphor is by far the strongest and the discussion mainly is about whether the line is continuously rising and hierarchical, or different for different individuals. (Tuomi 2001, 13-16.) Different philosophers have distinguished between three and twelve phases in the life course. The general way life course is viewed may decide how people of different age are treated in society; for instance, old people may be considered less valuable than the young. (Tuomi 2001, 18-34.)

Lopata & Levy (2003, 4-5) have identified five central themes of the life course paradigm:

- 1) *The interplay of human lives and historical times that give rise to “cohort effects” in which social change differentiates the life patterns of successive groups of people born within a socially defined and bounded period of years.* Different generations can thus have very different life experiences.
- 2) *The social meaning of age, age-norms, and age-graded roles and events.* Different norms apply to people of a certain age at different periods of time.
- 3) *The timing, sequencing, and duration of life events including scheduling of multiple trajectories and their synchrony or asynchrony.* There are often expectations of in what order certain life events should take place. For example, you are usually expected to marry before having children. What is “the right age” for a life event is being discussed and may change. For instance, in the western culture it is nowadays seldom seen as a catastrophe to have a child before getting married or without ever marrying at all.

- 4) *The linking and interdependence of lives.* Through social relationships our lives are linked to the lives of other people, for instance family, friends, neighbours etc. A divorced couple may find that, through their children, their lives are interlinked long after they have divorced.
- 5) *The human agency in choice making.* We plan our lives within the limits of the social and the physical world. For instance, some university students may plan to continue studies after a bachelor degree, while others plan to enter working life. Differences in plans may come from personal preferences or they may reflect differences in how the students view what is possible and available to them.

Life course theories are based on the assumption that people experience certain events, transitions and turning points in their life. Many of these transitions are set by the institutional system of society, which sets requirements of age for certain actions. There is a set age or age expectations for when you start school, get your driver's license, do your military service, vote, buy spirits, retire from work etc. But in reality people's lives seldom turned out like the "ideal" life. Many unexpected events may happen during the life course. (Lopata & Levy 2003, 5)

2 SOCIAL CONSTRAINTS

Everybody is born into a social context of some kind; certain social conditions determine the life opportunities of that particular group of people to which the person belongs. In a class society these opportunities are very strictly regulated, but also in less class-divided societies there are different kinds of social constraints inside of which people shape their lives. Our life is affected by the family we grow up in, the schools we attend, the friends we have, the economy of our parents and later of our own economy, our own and our family's health status and so on. Moreover, many kinds of unexpected events occur during life course, both positive and negative. Some of the negative events can be neutralized, some not. Some of the unexpected events pertain to health and childhood experiences. Health problems may cause a need for vocational rehabilitation, and childhood experiences may affect the choice of vocation. Two concepts, which can serve as examples of social constraints in a person's life, are 'social determinants of health' and 'adverse childhood experiences'. These concepts will be described briefly.

The World Health Organisation describes social determinants of health (SDOH) in the following way: *Even in the most affluent countries, people who are less well off have substantially shorter life expectancies and more illnesses than the rich. Not only are these differences in health an important social injustice, they have also drawn scientific attention to some of the most powerful determinants of health standards in modern societies. They have led in particular to a growing understanding of the remarkable sensitivity of health to the social environment and to what have become known as the social determinants of health.* (Social Determinants of Health...2003, 5.)

Adverse childhood experiences (ACE) again are experiences of long-term abuse and dysfunction in the home that a child may have, while growing up, and which may have a harmful impact in adult life. These experiences have been studied among others by a group of American researchers who define adverse childhood experiences in the following way: *Growing up (prior to age 18) in a household with: recurrent physical abuse, recurrent emotional abuse, sexual abuse, an alcohol or drug abuser, an incarcerated household member, someone who is chronically depressed, suicidal, institutionalized or mentally ill, mother being treated violently, one or no biological parents, emotional or physical neglect.* (The Adverse Childhood Experiences Study 2003-2004.) Many studies (e.g. Dube et al 2003) suggest that childhood abuse can lead to negative health outcomes and health behaviour. Many, although not all, clients of social work have this kind of experiences, which may come up later in vocational rehabilitation.

3 BETWEEN SOCIAL CONSTRAINTS AND THE FREE WILL

The relationship between the individual and the society has been described in different ways depending on whether the focus is on the individual or on society. Thus there are different theories on to what extent people can plan their own life, i.e. exercise their “free will”, and to what degree they are victims of the social conditions they were born into and grew up in (social determinism).

‘Identity’ is often seen as a sociological concept which refers to how the individual builds up a story about him- or herself, where social and cultural factors have a great impact. Johansson (2002) uses the psychological concept ‘self’ to stress the importance of a person’s inner experiences while at the same time emphasizing that analyses of self can and should be contextualized in a certain social and cultural environment. (Johansson 2002, 25-29.) He identifies four dimensions of self: the private self, the

split self, the disciplined self, and the extended self. Research on the 'private self' focuses on the space of the individual to think and act freely in society. Researchers disagree on how large this space is, and whether the space for autonomy is growing or diminishing in society today. Another interesting question is how the private and the public sphere intertwine. The self was earlier seen as given and as being threatened by the surrounding environment. Nowadays the private and the public spheres are seen as intertwining and as forming each other. We talk about the reflexive individual in the postmodern society. In the constant flow of information people seek tools that can help them better understand themselves and the society they live in. People pick frames for understanding and perspectives wherever they can, anywhere from mass media to scientific knowledge. Everybody is not able to understand and use all this information flowing. The well-educated and well-off have more opportunities and can use these opportunities to strengthen their own positions. (Ibid, 42-48.) The second dimension of self, the 'split self', has to do with the discussion about ontological insecurity, a true and a false self, the pathology of society etc. (ibid., 73). The 'disciplined self' again refers to the discussion about the individual being disciplined into a cultural being and the questioning of the idea of individuals as unique and acting subjects (ibid., 87). Finally, the 'extended self' refers to the changes of individuals and society which make it possible for a person to be in (virtual) contact with the whole world without having to go out of the house. The borders between self and the rest of the world dissolve. (Ibid., 91.) According to Johansson self should be studied at four levels: in relation to the structural changes in society (e.g. industrialization, postmodernization, information society), in relation to the positional changes in people's economic and material conditions (e.g. class, gender, ethnicity), in relation to the concrete social and cultural contexts people live in (personal networks, material circumstances, power relations), and in relation to the informal 'institutions' of everyday life (family, friendship, colleagues, work, media) (ibid., 106-107).

Work is still very important in our culture. A lot of the identity work is done in the work sphere and at some point it may be difficult to separate paid work from the rest of everyday life. (Johansson 2002, 153.) Working life has changed a lot, but there is a difference between normative changes and real changes. A flexible, free and constructive way of relating to work is highly valued in society of today, but this is not possible for everyone. (Johansson 2002, 156.) Working life may be seen both as itself a social constraint and as the result of social constraints earlier in life.

A problem for social scientists in the study of sociological phenomena has been how to, at the same time, take into account the objective life conditions on one hand and the subjective will and personal experience on the other. In his theoretical construction of the habitus theory the French sociologist Pierre Bourdieu (1980, 43) has tried to reconcile the differences between objectivism and subjectivism. A person's habitus is abstractly defined as the system of internalised dispositions which link together social structures with practical activity. (Brubaker 1985, 758.) Habitus is a system of dispositions, which makes it possible for people to act, think and orient themselves in the social world (Broady 1990, 228). Habitus is formed by the social conditions in which the individual grows up, i.e. the individual is from earliest childhood imprinted by his or her social environment, in particular the family and the way in which social constraints manifest themselves in the life of the family. The dispositions are adapted to certain social conditions, the same that prevailed when the dispositions were produced, and therefore they are also adapted to the possibilities and impossibilities, the freedoms and necessities that these conditions contain. This means that habitus gives people a certain freedom to act and to take a certain outlook, a kind of conditioned freedom where certain acts, thoughts and aspirations are perceived as impossible from the very start. But within a given spectre the individual has the possibility to think, perceive and act. By this Bourdieu wants to say that people's behaviour is neither the result of a totally free will nor a mechanical reproduction of the original conditions in a deterministic sense. (Bourdieu 1980, 90-92.)

Bourdieu sees habitus as the explaining link between social conditions and the behaviour of individuals. He uses the terms 'embodied' or 'incorporated' instead of 'internalised' in order to show that habitus is not a question of directly transferring norms from society to the individual but that the dispositions have been engraved in people's bodies by the social experiences they have had. (Broady 1990, 231-232.) The idea of embodiment can be found e.g. in recent discussions on the embodiment of social class (see e.g. Krieger 2001 and Rose 2006).

Habitus is thus the product of an individual's whole biographical experience. Therefore there are as many different habituses as there are individuals. (Bourdieu 1985, 82.) The theory of habitus can help us understand, why people do not necessarily act in a way that helps them to a better life or why changes happen so slowly. People do act out of an 'interest', but this interest is not always intentional and rational. Habitus is not unable to change, but the change is slow. In fact, habitus is constantly changing,

but when habitus is unable to adapt quickly enough to changes in the environment, intentionality and rationality come into function. (Bourdieu 1988, 43-44). Habitus may help us understand why a person's vocational career has developed in a certain way. The discussion about habitus can be viewed in relation to the new concept of 'biographical work', which is defined in module B.2.

4 LIFE COURSE AND VOCATIONAL CAREER

Participating in working life and having a vocational career is important to most people, although it may not be the only important content of a person's life project. The working age in Finland is generally considered to be 15-64 years, but today this is no longer the case. At 15 years of age no more than 10% of the age group is working, at 20 only 40% and at 25 about 70%. Not until after 35 years of age does the proportion of the employed rise to more than 80% of the age group (according to the statistics from 1999 of the Ministry of labour and the Ministry of social affairs and health). Compared to many other Western countries the actual retirement age is low, which is a general concern particularly with regards to the economy and maintaining the welfare society. When the large age groups retire, there will be a shortage of labour while, at the same time, the expected life span is increasing. (Ilmarinen 2001, 173; 188.) Steps to raise the age of retirement have been taken.

Young people get into the labour market later than before, because education lasts longer and because many young people are not able to find a job. Long-term unemployment has many negative consequences for the physical, mental and social health of a young person. Health behaviour in turn affects the working capacity and the employment opportunities. A strong sense of mastery in young age has been found to correlate with experienced good health, healthy living habits, low stress level and a good economy and education as an adult. Working capacity has a great impact on a person's life course. It is determined by health and functioning, education and know-how, values and attitudes as well as by motivation and work satisfaction. Both the working capacity and the work will change during a person's vocational career. Adapting working capacity and work to each other is an ongoing process. (Ilmarinen 2001, 173-174.)

The health of employees generally changes during their vocational career. Health problems occur even among younger employees. More than 25% of people in Finland

aged 25-34 have a chronic illness or a handicap. In the age group of 45-54 the figure is about 50% and in the age group of 55-64 about 70%. More important than the morbidity of different age groups is how the individual experiences of the illness affect the working capacity. About 40-50% of the chronically ill say their illness has a negative effect on their working capacity. The discussion about how work could be better adapted to the employees' health is very weak in Finland; compared to other countries in the EU working life is very stiff. In Finland, Austria and Germany almost one third of men over 45 feel that chronic illness has a negative effect on their working capacity. In Sweden and Denmark the figure is only 10%. (Ilmarinen 2001, 180-182.)

Entering working life is one of the biggest changes in a person's life, even if this nowadays seldom happens just once and permanently. The young person gains greater autonomy and there is a new life rhythm. Learning the job, getting new skills and cooperating in the world of adults demand time and perseverance. It is estimated to take several years for a young person to become integrated and a full-bodied member of a workplace. Learning new things and succeeding in the job enhance self-confidence, whereas disappointments and mistakes enhance self-knowledge. Research shows that there will be a great demand for young people in the labour market in the future. Young people in Finland are found to be strongly work-oriented and the content of the work is more important for them than the salary and the relationships at the workplace. The future good position of the young in the labour market will make it easier for them to change between employments, but expectations on them will also grow. This may mean new opportunities but also considerable demands, which may be hard to manage. Young people cannot always judge their own strengths, but psycho-physiological limits pertain to them, too. The youngest 'burn-out' cases in Finland have been 28 years old, and the process has sometimes taken only six months. (Ilmarinen 2001, 175-176.)

When young people enter working life, their living habits and health behaviour change considerably. There may not be time for exercise, and the physical condition may deteriorate quickly. Another big change often occurring in the beginning of the vocational career has to do with establishing a relationship and forming a family. The position in the labour market at this point is often still rather insecure. Just like older age groups, young employees, too, need greater flexibility in their work, although for other reasons. (Ilmarinen 2001, 176-178.)

Even for those who are what one would call 'integrated' into the labour market working life is hardly calm and stable. Employments today are often linked to projects, or in temporary, part-time or distance jobs etc., which makes the vocational career more shattered. Work tasks are also changing, becoming more demanding and diversified with growing demands for efficiency and quality. Demands on organisations have also changed, and these changes affect the performance of the employees. Values have changed: the new type of organisation stresses the resources of the individual, life being in control, good mental health and working capacity as well as good communication skills. New production methods, new technique and new work contents may offer interesting challenges, but on the other hand badly organized work and weak leadership may affect the health and the working capacity of the employees. Uncertainty of the employment and quick changes in working life may make employees feel a pressure to continuously improve their professional skills. Life-long learning has become not just a challenge but also a necessity. (Ilmarinen 2001, 178-180.)

One factor which improves with age is mental maturity. Many cognitive skills improve, such as strategic thinking, smartness, caution, wisdom, reflective and arguing skills, ability to grasp complex systems, and mastering a multifaceted language. Older employees may also be strongly motivated for further studies, if they view them as useful for their work. Employees over 45 have been found to be absent from work less often than younger employees. Younger employees are less often absent because of sickness but more often for other reasons (e.g. sick children). Other factors that may favour older employees are a longer working experience and a better control of their daily life. In spite of this, after 45 years of age there is a polarisation of the labour force into those whose working capacity is weak and those whose working capacity is good. Older employees need more individual solutions in their work. (Ilmarinen 2001, 182-185.)

In leadership education there is now a growing understanding of life course issues. Employees of different age and in different phases of life need different types of management in order to be able to use their working capacity in an optimal way. Leaders in general need more knowledge about aging and about supervising aging employees. (Ilmarinen 2001, 185.)

The need for vocational rehabilitation may become a fact for even larger groups of people as retirement age rises and the changes in working life become even more rapid.

Exercises

1. Read an autobiography or a biographical novel, or watch a film or a play telling about a person's life (fictive or real). Try to identify the interplay between social constraints and moments when the main character is exercising or trying to exercise his or her "free will".
2. Think of your own life: What made you choose to become a social worker (or your present vocation)? Was it your own choice? Did you have other options?
3. Recall silent presumptions in your childhood family. How did they affect your choices in life? Positive and negative ones.
4. Draw a picture of your life (e.g. a life line) putting in the social context and 'constraints' during different periods.

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III Biography, Narrative, and Rehabilitation¹

Johanna Björkenheim & Synnöve Karvinen-Niinikoski

SHORT DESCRIPTION

This module deals with theoretical frameworks of biography and a narrative approach in rehabilitation. It introduces some basic concepts and makes the connection to vocational rehabilitation.

LEARNING OBJECTIVES

1. Know some of the basic concepts in the discussion about biographies and narratives.
2. Understand the importance of confirming and working with clients' biographies and biographical narratives in vocational rehabilitation.
3. Be able to identify “biographical work” and possible “trajectories of suffering” in a biography.

1 INTRODUCTION

1.1 The history of narratives

Narratives are thought to be a very old cultural tool in human history. Story-telling was probably used as early as in prehistoric times for sharing important information in hunting-collecting communities. The stories helped people to survive in practical life and were also used for transmitting, forming and strengthening the morale of the community, necessary for survival. Stories were useful in imagining possible courses of events, necessary when making plans for the future, and presumably, listening to stories helped in acquiring skills to guess the intentions and frames of mind of other

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human beings. Stories probably had an “entertaining” and uniting function in the communities as well. (Hänninen 2000, 37-38.)

In the cultural history of narratives there is first a period of oral narratives and then a period of written narratives. In the oral culture stories were stored in the story-tellers’ minds, and narratives were often presented in a singing, poetic form. The story-teller was seldom the producer of the story, he/she only functioned as an intermediary. Later, with the literate culture, stories could be written down and the story-tellers could create new stories themselves. Written stories could also be interpreted, analysed and assessed in different ways. Stories are told through acting in theatre, as films, and on television, too. The difference between truth and fiction here becomes vague: the characters of a TV serial seem real whereas a real war can be watched as a TV program. (Hänninen 2000, 39.)

The recipient’s relation to narratives has become a more private matter compared to when, in the oral culture, listening to stories was a social event. As regards the contents of stories, three historical lines can be seen: a shift from picturing people’s acts and activities to describing awareness, thoughts and feelings; a shift from presenting stories with one “truth” to telling stories in a dialectic way presenting several different perspectives; a shift from presenting stories with one plot to presenting stories with several main themes or even completely abandoning the conventions of story-telling. (Hänninen 2000, 40.)

The biographical literature has created a mediating category between the fictive story and real life. A biography tells about the life of the writer from his or her subjective perspective. Although biographies have been written since classical antiquity, “Confessions” by Father Augustine, who lived in the 4th and 5th centuries A.D., is regarded as the pioneer work of modern biographies. From the 17th century on, writing biographies became more common, and now biographies are written not only by well-known and prominent persons but also by “ordinary” people, especially people with dramatic life experiences. (Hänninen 2000, 40-41.)

The significance of stories as mediators of morals has changed. Children used to be brought up with models and warning examples in stories with a moral. Modern children’s literature rather attempts to break than to strengthen traditional moral conceptions. Also in stories for adults reflection on moral questions has become more common. The moral of today’s stories often is that there is no one set moral. (Hänninen 2000, 41.)

The place of narratives in culture has changed. In pre-modern societies narratives were a tool for making the world understandable and meaningful. In the modern society, the goal being to find the “truth” to serve rationality, narratives were not seen as so important, even though modern culture itself is grounded in a narrative, i.e. the myth of progress. Today the view is that events can be interpreted in different ways, and that different stories can be told about the same event. (Hänninen 2000, 41.)

1.2 Narrative research

The core of narrative research is the analysis of stories. Narrative research has spread during the last decades from research of literature, sociolinguistics, history, and philosophy to other sciences, such as social sciences and psychology. Narrative research does not have one unified and clearly defined theoretical-methodological structure but is rather an open net of discussion with the term ‘narrative’ in common. (Hänninen 2000, 16-19.)

The study of autobiographies started out with reading them as accounts of the lived life. During the last decades researchers’ interest in biographies has focused not only on the contents, i.e. “what really happened”, but also on the way in which the story is told. For instance Schütze (see Riemann 2003) found that systematic study of how a story was told could help in better understanding what really happened, i.e. the experiences of the narrator and the social processes in which he or she had been involved.

The data in narrative research usually consists of stories told in interviews or in writing. Oral interviews, i.e. extempore narratives, are usually very different from written stories in that they have not been constructed in advance (Riemann 2003).

2 BIOGRAPHY AND NARRATIVES - THEORETICAL FRAMEWORKS

2.1 ‘The narrative flow’

In order to clarify the concept of ‘narrative’ Vilma Hänninen proposes a model she calls ‘the theory of narrative flow’ (figure 1), which distinguishes between the different dimensions of narrative and shows how they relate to each other (Hänninen 2000, 106-109).

Theory of narrative flow

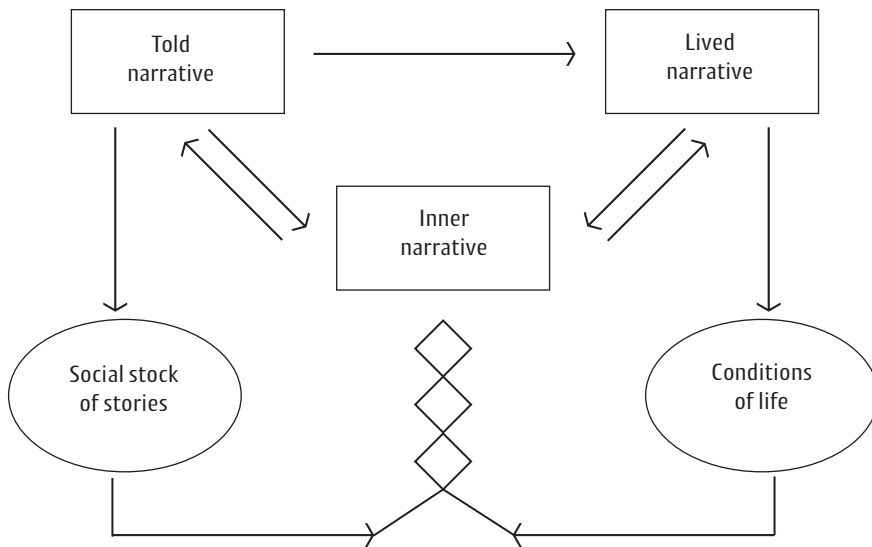


Figure 1. The model of narrative flow according to Vilma Hänninen (2000).

‘The inner narrative’ is defined as “a mental process by which people make sense of their lives and their situation”. It presumes that a person lives his or her life as if it were a story, in which he/she is the main character. The inner narrative can, but does not have to, be made explicit in told narratives. The inner narrative operates on three levels, i.e. as original, reflective and metareflective narrative. The original, unreflected narrative is working, when a person’s life projects proceed without major changes. The reflective narrative is the narrative a person tells himself or herself e.g. when trying to make sense of a problem situation. And the metareflective narrative refers to the conscious reflecting on the inner narrative, knowing that it is a narrative. (Hänninen 2000, 19-22.)

The ‘lived narrative’ (drama) in this theory is the activity whereby a person tries to realize his or her narrative projects formed in the inner narrative. The term ‘lived narrative’ is used instead of ‘life itself’ to emphasize that people’s actions, decisions, and intentions are guided by the narratives they live by. The lived narrative is subject

to social constraints and also unfolds as an interplay with the lived narratives of other people. The narrative flow is thus shaped by and shapes the cultural and socio-material conditions. The consequences of the lived narrative will change the inner narrative. (Hänninen 2000, 20-22.)

The 'told narrative', finally, is the story a person chooses to tell others about himself or herself. The form and content of a told narrative may vary in different contexts. It is in itself a social act, which can have social effects. There is a socio-cultural stock of stories from which the inner narrative can draw its models and where the told narrative is included. The theory of narrative flow describes the process whereby a person relates at the same time to the socio-material reality and to the discursive reality. (Hänninen 2000, 20-22.)

2.2 Life stories and culture, class, and gender

The way people narrate their life stories is not the same all over the world. It differs depending on culture, class, gender etc. The construction of an individual self is seen as typical for the Western culture, where an autobiography is supposed to reveal the psychological depths of the individual narrator. In other cultures it may be seen as quite irrelevant to narrate a story where the individual self is in the centre of the story. The story may rather be about the role the narrator has in the tribe, and the appreciation this gives him. (Johansson 2005, 229-231.) Even within the Western culture ways of narrating differ between groups. For instance the oral narrating tradition of the working class differs from the written narrating of the bourgeoisie. (Johansson 2005, 239.)

Anni Vilkkö, who has studied mainly written autobiographies of Finnish women, points out that there is no life story without a gender, and the narrated gender connects cultural and personal issues and ideas in the narrative of the self. The recipient of the story is an embodied reader or listener, the other, who in interpreting the narrative uses elements that refer to lived gender, cultural gender and the gendered reader's/listener's perception of the narrative. (Järviluoma et al 2003, 46.)

In the autobiographies of Finnish women Vilkkö identified three types of metaphors for life, one of which describes the activity of bringing shape and order to disparate and confusing elements (threads in a fabric, a cloth on the loom, a rag rug, a patchwork quilt, a jigsaw puzzle). The activities and products connected to this type of metaphor

are traditionally typical of women and can be seen as producing a gender-specific autobiographical language. (Järviluoma et al 2003, 51.)

Feminist writers argue that the norms for writing autobiographies established through the autobiographies of men like Augustine, Montaigne, Rousseau, Goethe, and Darwin tend to marginalize women as writers of their lives. The female self in autobiography has been described as “self-effacing, oriented to private life, sensitive to others’ needs, relational and subjective, anecdotal and fragmentary in composition”, whereas male self-narratives are read as “self-centred, self-assured and independent, linearly organized, and oriented towards public life, and socially notable personal achievements”. (Järviluoma et al 2003, 54.)

Just like autobiographies in general, women’s autobiographies were first read as accounts of the life lived. Normative events, life transitions and social relations were found to be important in women’s lives. Men and women were seen to interpret the world differently and thus living in separate life worlds. Women’s world was seen to be that of the private and personal, whereas men’s world had to do with acting and achieving in public domains. Women’s self-narratives were found to be fragmentary, incoherent and non-linear compared to men’s coherent and linear self-narratives. Women’s different way to narrate was thought to stem from their subordinate social status and from defining themselves through addressing the needs of others. Even women who had achieved a high position in society often narrated their lives as passive objects and in relation to someone else’s life events, often their husband’s or their father’s, rather than as active subjects. (Järviluoma et al 2003, 55-56.) In the mid80s many feminist researchers thought that there was a difference between men’s and women’s self-representations disregarding locality. Others thought that underlying social practices which produce differences in gender identities should not be ignored. Narrative research was promoted by the idea of self-narratives functioning as emancipatory, giving a voice to the silenced, including women, and to communicate their experience of life. (Ibid., 60.)

At some point, researchers realized that language is not just a tool for telling about real life events. While telling others about our life we are constructing our identity. With the move into the postmodern era and the conception of an identity that consists of many different, disconnected identities the view on how self-representations should be done also changed. It became accepted for men as well as for women to tell their stories in a fragmented incoherent way. In fact, it was seen as impossible to create a

coherent life story through autobiographical reflection. It was also acknowledged that women from different ethnic groups and sexual minorities do not necessarily tell their stories in the same way. (Järviluoma et al 2003, 61-62.)

Life histories are no longer seen as just documentaries of 'real' life but also as a constructive act of reflection, where factors as culture, class, gender etc. are always present. What Vilkkko says about gender you could say about culture and class, too: There is no life story without culture, class or gender.

2.3 Biographical trajectories

In a biography it is possible to distinguish certain structural processes. There are the institutional expectation patterns/careers of the life course, the metamorphoses of the biographical identity, (e.g. the flourishing creativity of an artist), and the biographical action schemes (the plans a person makes for his or her future). (Riemann & Schütze 1991, 348.)

The concept of 'trajectory' has been used to discuss suffering and disorderly social processes, although the word in general speech neutrally signifies e.g. the course a ball takes, when it is thrown. The concept of 'trajectory' was used by Glaser and Strauss (1968; see Riemann & Schütze 1991) in their research on the course of serious illness and dying to provide a theoretical framework for discussing the relationship between the course of an illness and the work the sick him/herself and people around him/her do to "manage" that illness. The concept takes into account the constant dynamics between inner and outer aspects of a person's situation. Riemann and Schütze broadened the concept in order to find out, whether it could be used in a more general sense, for instance by professionals who work with persons in complicated life situations, e.g. social workers. They developed the concept of 'trajectory of suffering' and defined it as "the conceptually generalized natural history of disorder and suffering in social processes". This concept is viewed as a promising tool for professionals in seeing and understanding the trajectory potential and the destruction it may lead to. (Riemann & Schütze 1991, 333-334, 336, 352.)

According to Riemann and Schütze processes of severe suffering can and should be analyzed as biographical phenomena, i.e. as phenomena that affect e.g. work and interaction in a context of socio-biographical changes in the life course and life

situations of a person and his or her family. Severe suffering touches the personal identity of those personally involved in the trajectory, and changes of identity affect the interaction, communication and work processes. The biographical processes consist of a person's life history experiences, which are produced, or at least interpreted and stored, in social interaction. A person's identity changes during the life course and so does his or her relationship to the present, to personal history and to the future. The change in a person's relationship to him/herself takes place through biographical work, i.e. work of recalling, interpreting, and redefining, which is done in communication with other people, especially with significant others. Biographical processes, which by definition have to do with changes of personal identity, are more difficult to study than social processes, because many aspects consist of 'inner events', which are not easily accessible to empirical observation. However, they can be studied through oral and written autobiographical narratives. (Riemann & Schütze 1991, 338-339.)

The order of a person's everyday life is upheld by institutional expectation patterns (the normative principle) and by biographical action schemes (the intentional principle). Trajectory processes are seen as processes that disturb the social order, and they can have detrimental effects on a person's life. Riemann and Schütze have described the cumulative disorder of a biographical trajectory as consisting of six chronological stages:

- 1) *Build-up of trajectory potential.* A trajectory may sometimes start suddenly, for instance through an accident, but usually it starts slowly, e.g. a chronic illness. Strong outer forces gradually build up a so-called trajectory potential in a person's life situation, like when dark clouds start to gather in the sky before a thunderstorm. The person notices that something fatal may be happening and either prepares to fight or tries to actively "forget" the hidden signs of trajectory. The person's own actions and reactions can add to the trajectory potential, for instance, the person goes ahead with his or her plans, which in that situation only will make things worse.
- 2) *Crossing the border from an intentional to a conditional state of mind.* The person realizes that he or she is now driven by outer forces and that the usual action strategies are of no use. Every day the person has to take into account that outer forces may overthrow his/her plans, like when a person with a serious illness on an invitation has to answer: "If I am well enough on Friday, I will come."

- 3) *Precarious new balance of everyday life.* After the person has overcome the first shock of not being able to make plans as usual, there is a new, although unstable, balance in his/her everyday life. However, the constant work of trying to balance between what he/she can and should do and what he/she cannot do is very exhausting. Actions to diminish the trajectory potential are therefore not always adequate. Strauss et al talked of the 'cumulative mess' meaning that the process is aggravated by attempts to solve some of the problems while at the same time worsening others. Different sets of problems having a worsening effect on each other.
- 4) *Breakdown of self-orientation.* As new events occur and the person makes more irrational attempts to stop things from becoming worse (like drinking excessively), the situation is getting only even more critical.
- 5) *Attempts of theoretically coming to terms with the trajectory.* Being at a total loss is a shock. The person knows that something terrible has come into his/her life but does not understand what it is and how it came there. He/she realizes that the situation cannot be handled with the usual resources and that the life situation needs to be completely redefined. The person's new definition of the situation aims at describing the suffering, how it works and the reasons for it, at tackling the question of dealing with an unjust fate accepting or rejecting the trajectory, and at fighting the impact of the trajectory on the life course.
- 6) *Practical working on the trajectory or escaping from it.* Depending on how the person has defined the new life situation he/she starts to act systematically to either control or escape from the trajectory. Three types of action schemes are possible in handling the trajectory:
 - (1) To flee the present life situation, which usually does not help, because the person is still defining himself through the trajectory.
 - (2) To reorganise the life situation in a way that it will be possible to live with the trajectory. This may mean that new biographical action schemes are possible, and that processes of so-called creative metamorphosis get started, i.e. completely new resources for self-realization emerge.

- (3) To work systematically on eliminating the trajectory potential, if possible.
This is done by reorganizing the life situation completely and by doing biographical work.

(Riemann & Schütze 1991, 339, 348-352.)

Connecting to the discussion on habitus in module A.3 we can say that at the start of the trajectory the person's acts are determined by habitus, which may produce unadequate behaviour. As the process goes on, the person is at best able to act more rationally. In this process of biographical work social workers and other professional caretakers can have an important role helping the person to reorganize his/her life situation either living with the trajectory or planning for a life where the trajectory can be avoided.

3 NARRATIVES AND REHABILITATION

3.1 Life course and working life

As mentioned earlier (module A.3), age is an important factor in making plans for the future: At what age will I do what? Institutional schedules for the life course refer to the societal expectations as to which life events should occur at what age (although what age is 'suitable' for what event may vary from culture to culture and over time). There are certain age-norms related to e.g. taking your driver's license, finishing school, getting married, having children, having your economy in order, having grandchildren, etc. If, for some reason, the expected life events do not occur, when they are "due", or do occur when they "should not", this is considered more or less deviant from the normal pattern.

The institutional schedules also apply to working life. In Western society you are supposed to have finished your studies and have a profession at a certain age, have made a career at a certain age and retire from work by a certain age. Adults are generally expected to do work of some kind, at home taking care of their small children, as self-employed or as employed by someone else. Most women nowadays want to have a vocational career of some sort, even if they take care of their children at home for some time. The time spent at work (or thinking of work matters) make up for

quite a large part of people's life, and so the future vocational career is something many young people think a lot about.

During the life course many life events take place. Often the sequence of the events is seen as important and there may be several different so-called socio-biographical processes going on at the same time. These may sometimes collide and compete, for instance the vocational career may be difficult to combine with family life, or processes with different groups of people and friends may collide with the process of getting a profession.

3.2 A definition of rehabilitation

Mastering your life is one of the most important values in our culture. People try in different ways to gain control over their life or parts of it. Even death is something people try to control. It has become more common to explain human activity by the goals and initiatives of the individual rather than by the outer conditions in the person's life situation. Nowadays, for instance, we think that it is not possible to gain control over an illness without your own will and efforts, even if rehabilitation and other experts may have an important role in the process. Mastery can be seen as a resource essential to reach the goals of the rehabilitation interventions. It may also, however, be seen as a goal in itself, where the individual's self-confidence and possibilities to self-realization are seen as a central aspect of being human. (Järvikoski 1994, 98-99.)

Rehabilitation as activity has changed with the changes in society. After World War II it was important to rehabilitate disabled war veterans into the labour force to rebuild society (Järvikoski 1994, 130). Restoring working capacity is still important in rehabilitation, but now there are other important aspects as well. The goal of rehabilitation may be to improve functioning in general and to enhance social integration. (Järvikoski & Härkäpää 1995, 15-20.)

Järvikoski & Härkäpää (1995, 21) have defined the concept of rehabilitation as supporting mastery of daily life in the following way:

“Rehabilitation is a planned and multisectorial activity which

- has as its general goal to help rehabilitees carry out their own life projects and maintain mastery in situations where their possibilities to manage and to be integrated into social life are threatened or weakened due to illness or for other reasons,
- is based on a plan made by the rehabilitee and the rehabilitation worker in collaboration and is subject to continuous process evaluation also performed jointly by the two parts,
- consists of interventions aiming at increasing the individual’s resources, functioning and mastery, as well as interventions aiming at improving the conditions for better functioning in the society where the person lives, and
- can be based on work with individuals as well as with groups and can make use of social networks in the community.”

When a person’s working capacity for one reason or other has changed so much that it is difficult or impossible for him or her to continue in the same work as before or to perform the same tasks as before, the rehabilitation work needed to help this person carry out his or her life project may have to consider the person’s life history and biography. How can this be done in a meaningful and successful way?

3.3 The narrative approach in rehabilitation

Narratives have been used to gain a better understanding of people’s experiences of their illness and their life situation. They have also been used in rehabilitation. From a narrative perspective people try to make sense of their own life by seeing it as an intelligible narrative with a “plot”, looking back, over the present, and into the future. Events, experiences, thoughts, and feelings during the life course are linked together by the meaning the person him/herself gives to them. A life story (narrative) is thus the person’s own interpretation of his/her life. In principle, it is possible to interpret a situation in different ways. Certain events and episodes, seen as particularly significant, are selected for the life story while others are forgotten or put aside. A person may, for

example, remember only the injustices and failures in his/her past and see only threats in the future (i.e. life is interpreted as a tragedy). The story, both the interpretations of the past and the projects for the future, is transformed over time and with changes in the life situation. When a person starts to reflect on his/her story and realises that the interpretation of previous life events can be changed, this may liberate him/her to seek a new perspective for life. (Hänninen & Valkonen 1998, 3-4.)

In a narrative perspective rehabilitation can be viewed in part as the work of supporting the rehabilitees' efforts to create narratives that are meaningful to them, and to help them realize these narratives. An important task in planning and developing rehabilitation services is reflecting on the presumptions and model narratives established in the rehabilitation workers' own ways of acting and talking. Is there room for alternative narratives or are the experiences of the rehabilitees pushed into one form? (Hänninen & Valkonen 1998, 10-11.)

In narrative rehabilitation the language is important: is the focus on problems and deficiencies or on the goals and the strengths of the client? The paradox is that in applying for rehabilitation services the person (at least in Finland) has to prove a deficiency or a deviance, which is a negative starting point for rehabilitation. At the same time the client is required to concentrate on his/her resources and strengths, which are the positive basis for rehabilitation. (Hänninen & Valkonen 1998, 11-12.)

In rehabilitation it is nowadays stressed that the rehabilitee should be the subject and not the object. In narrative terms this means that the rehabilitation should strengthen the person's experience of being the main character in his/her own life including her rehabilitation. This may not always be easy, especially if the client has accepted a passive sick role. The role of subject in rehabilitation should be strengthened by bringing the rehabilitee into the planning work of the team. (Hänninen & Valkonen 1998, 12.)

The traditional task of rehabilitation to improve functioning can, in a narrative perspective, be understood as helping people to realize their own stories. This means improving the functions that are necessary for realizing the goals of the particular client. Someone may want to write a book, another to take care of his or her grandchild, or to be politically active. These different goals imply different needs for improved functioning. But the personal goals meet social reality. The possibilities of realizing social roles may, as a consequence of the illness or handicap, be diminished.

In that case the challenge for rehabilitation may be to raise new types of narrative projects, and to make them possible and valued. The new narratives will have to be accepted and respected by the rehabilitee as well as by persons or communities significant to him/her. According to Hänninen and Valkonen, it is not necessary to encourage the rehabilitee to create a logic and coherent story with clear goals; often it is better to support him/her to accept a story that is complex and open, and to encourage him/her to enter a world of more vague, inexplicable, and irrational stories. One central dimension of narrative rehabilitative work could be to let aside the individual model stories and get closer to more general and basic meta-stories instead. (Hänninen & Valkonen 1998, 12-15.)

Research shows that it is essential for people in rehabilitation to hear the stories of other people with similar experiences and to tell others about their own experiences. This is a way for people to see that they are not alone with their problems and that others have the same kind of experiences. Hearing other people's stories can give support and strengthen a person's own identity. In a group of rehabilitees a normative model story may be created, which strengthens the solidarity between the group members. Alcoholics Anonymous is a good example of this. However, a person whose experiences do not fit with the model story may feel excluded from the group. It is therefore important that the group will allow different stories to be told. Hearing stories that are different from your own may be useful in that it opens up new perspectives. (Hänninen & Valkonen 1998, 13-14.)

3.4 Diversifying the socio-cultural stock of narratives

The cultural stock of narratives offers people in a society a shared frame for understanding life experiences and events. Model stories about illness offer interpretations e.g. about the responsibility for illness and rehabilitation and about the direction rehabilitation should take. Model stories can be labelling and oppressive, or they can be encouraging and supporting. However, one or two formulas can never hold the complexity of real experiences. In a study of laymen's model stories about myocardial infarction (which they themselves had not had) five story types were found: the most common one was about health behaviour and the most important value of rehabilitation was to promote a healthy way of living. The metaphor of the second story type was a fight, where illness was seen as a threat towards a dignified

life, and rehabilitation was seen as bringing the person back to a life of dignity. The third story type held a metaphor of emancipation: illness was seen as a consequence of the demands of society, and rehabilitation meant liberation from the demands. The fourth metaphor described the illness and the rehabilitation as the decree of fate, and the fifth one described both the illness and the rehabilitation as just due to coincidence. These cultural stories may limit the ways in which a person with myocardial infarction understands his/her situation. In order to be able to live a story that is different from the common ones, the rehabilitee needs to get understanding and social confirmation from others. It is not easy to carry out an optimistic story, if everybody around you regards your illness as an unavoidable tragedy. It is not easy to accept your illness, if your social environment demands you to fight it actively. And it is easier to accept your sadness and rage, if there are other kinds of stories available than those about how sick people bear their illness with calm dignity. Narrative rehabilitation, i.e. the creating, forming, telling and realizing of life stories, would be much easier, if different kinds of narratives were presented in public. Besides helping other people suffering from illnesses, stories of people with own experiences of illness and rehabilitation can point at new existential dimensions. (Hänninen & Valkonen 1998, 16-17.)

Narrative rehabilitation means not only that former rehabilitees can tell other people their life stories in a new way, or even that they to themselves interpret their lives in the light of a new narrative. In the end, rehabilitation is a question of getting the opportunity to live a meaningful life and to realize your own life goals in real life. The limits of the stories of real life are set not only by imagination, but also by very complex social, cultural and physical structures. In the case of an illness or handicap these limitations can be extremely narrow. In order for people to have a choice and be able to realize not just one type of life story, there needs to be more equal access to work, education, leisure, and other fields of everyday life. Rehabilitation workers cannot renounce the responsibility for the work of creating this kind of opportunities. In a narrative perspective, rehabilitation has often worked with the goal to return the rehabilitee back to a “normal” life, to a certain type of “good life story”. Hänninen and Valkonen ask whether a task for rehabilitation should not instead be to work for a more differentiated supply of life stories? (Hänninen & Valkonen 1998, 17.)

Exercises

1. What institutional patterns can you see in your own culture?
2. What types of “model narratives” for a person being ill with cancer can you think of?

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IV Social work case analysis of biographical processes¹

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SHORT DESCRIPTION

This module deals with the analysis of biographies and narratives. It also presents ways in which biographies and narratives are used in social work, and gives an example of a case analysis.

LEARNING OBJECTIVES

1. Know something about how to analyse biographies and narratives.
2. Recognise ways of using a biographical approach in own work.

1 INTRODUCTION

Collecting and analysing personal and collective stories in a systematic way has long traditions in the social sciences. Biographical research is a "...field which seeks to understand the changing experiences and outlooks of individuals in their daily lives, what they see as important, and how to provide interpretations of the accounts they give of their past, present and future" (Roberts 2002, 1). A distinction is usually made between, on one hand, analysis of (biographical) "extended accounts of lives that develop over the course of entire interviews" and, on the other hand, analysis of "brief, topically specific narratives organized around characters, setting, and plot" (Riessman 2001, 82). An autobiographical interview focuses explicitly on the life history of a person while a narrative interview can focus on other things, too (Riemann 2003).

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In social sciences narratives have generally been studied in two ways: (1) from a methodological perspective, i.e. stories are seen as one of several sources to gain knowledge about the social reality, and (2) from an ontological perspective, i.e. the social reality itself is seen to have a narrative form. In the last case social and personal identities are seen to be constructed as stories. (Johansson 2005, 18.) In later years the story-telling aspect has gained in importance and it is common to talk more about life stories than about life histories. Researchers are interested not only in **what** is said but also in **how** it is said. How events are related in a story indicates how individuals give meaning to their lives. (Johansson 2005, 220; Riemann 2003.) The talk about ‘realism’ versus ‘constructionism’ or ‘narrativism’ is a key debate in much biographical research (Roberts 2002, 7). Öberg has introduced a third concept, i.e. ‘retrospective reflection’, which places itself **between** the realistic and the constructive position. This perspective sees “life-stories as windows, though not completely transparent, to history, culture and mind of the informants interviewed”. This perspective takes into account the fact that “individuals constantly reinterpret their life history according to their situation in old age and to their story’s plot”. (Öberg 1999, 110; see Johansson 2005, 223–224.) In this module narratives are seen as interesting both as to content and to form. By narrative we here mean a story about life (biography) or part of life.

2 ANALYSING BIOGRAPHIES AND NARRATIVES FOR SOCIAL WORK

When studying biographical processes in the work with clients, social work can gain from looking at how biographies and narratives have been used in research and what has been learned in this process.

Riemann (2003) mentions some important aspects, when doing autobiographical narrative interviews:

- 1 – It is necessary that there is a relationship of sufficient trust between interviewer and interviewee.
- 2 – The generating question has to be formulated in such a way that it can elicit an extempore narrative of the interviewee’s involvement in events and experiences that were relevant for the person instead of eliciting plain accounts or explanations as to why he/she acted in a certain way.

3 – The interviewee should be allowed to tell his/her story without being interrupted, except for when the interviewer gets lost and does not know what the narrator is talking about.

4 – After the coda (closing remark) of the main narrative there is a phase of questions and answers: the interviewer asks a few narrative questions in order to let the interviewee tell as much as he/she can about the main theme(s). When there is no more narrating, the interviewer can ask questions about certain facts or about the reasons for certain events or acts; these can be retrospective evaluations and reviews, reflections on what one would do differently today, what the events reveal about one's self etc.

In social work it is often necessary to ask about things that the client has not mentioned in the main narration. After having asked the interviewee to tell more about themes that came up in the main narration (internal narrative questions) it is possible to ask the client to tell more about themes that have not yet been mentioned (external questions). (Rosenthal 2003, 918-919.)

While telling his/her life story a person structures the story in a way that he/she finds meaningful. The memory process is supported and fragments are chained together to a whole picture. Narrating gives the best picture of what happened and of the experience. The story gets more detailed during the narration and the narrator starts to interact more with his/her memories, contemporary partners and with him/herself than with the listener. A biographical interview allows for themes to come up which the interviewer may not think to ask about. (Rosenthal 2003.) Disadvantages in social work can be that a biographical interview is work and time consuming and analysis is difficult, if it is not possible to tape and transcribe the interview.

2.1 Generating questions

In analysing biographical narratives it is important to look at what kind of questions, so-called 'generating questions', are used to generate them. The generating question influences the story and should therefore be part of the analysis. Professionals, e.g. social workers, usually have a different purpose with their interviews than researchers do, but the former can learn from the latter when it comes to formulating questions that encourage people to talk about their lives.

It is often necessary to start out with some small talk and be observant of how the interviewee responds. The interviewee, of course, needs to feel that the interview has some meaning and wants to know why it is being done. When doing a research interview in a medical setting, Riemann proposes starting with something like: 'I am not really interested in medical histories but in life histories' or 'in order to understand this part of your life....'. The interviewer should be vague enough in order not to restrict the interviewee's story-telling but specific enough, so that the interviewee knows what is expected of him/her. Riemann proposes that the interviewer pulls the interviewee into narrating by narrating something first, e.g. introducing himself/herself with a story. The generating question can then be just: 'Tell me your story!' followed by 'Start with your first memories!' (Riemann 2004.)

Other generating questions used in research are e.g.: 'Every person has a life story. Try to tell me about your life in about 20 minutes. Start wherever you want.' Or 'If you were to write a book about your life story, what would the different chapters be about?' (Holstein-Gubrium 1995, 40-41; see Johansson 2005, 248.) Sometimes it is more relevant to start out with a more specific question, like 'What does your work mean to you?' (Chase 1995; see Johansson 2005, 248.) Curran & Chamberlayne (2002, 2) used an open question in which the interviewee was asked to speak freely about his/her own situation.

In social work, too, it is common to use open questions that are not easily answered by a "Yes" or a "No". However, social workers may not usually ask questions that generate a whole biography. Often narrative questions (e.g. "Tell me more about...") are needed to help the interviewee tell his/her story.

Exercise 1.

What questions do you use in your work to generate clients' stories?

2.2 Analysis

Narratives can be read, interpreted and analysed in different ways depending on what questions are put to the material. One way to analyse autobiographical narrative interviews is described by Schütze in module B.2. Some general aspects of analysis will be briefly described in this chapter.

The model of Lieblich et al (1998, 12-14; see Johansson 2005, 288-290) identifies two main and independent dimensions in analysis of narratives: 1) holism versus category and 2) content versus form. The model is presented in figure 1.

	Content	Form
Holism	Holistic – Content	Holistic – Form
Category	Categorical – Content	Categorical – Form

Figure 1. Model for the Classification and Organization of Types of Narrative Analysis (Lieblich, Tuval-Mashiach & Zilber (1998, 13) modified by Johansson 2005, 288).

The holistic–content manner of dealing with narratives uses the complete life story of an individual and focuses on the content presented. The analysis can also focus on certain parts of the life story, usually the opening or closing parts, but the parts are always related to the entire life story. This kind of reading is common in clinical case studies and in anthropology. (Johansson 2005, 289.)

The holistic–form type of analysis involves looking at the structure of complete life stories. Is the story a comedy or a tragedy? Does the story contain a climax or turning point, which explains the development? How does the story begin and end? How is the story organised: chronologically or thematically? This type of analysis has become more common in social sciences during the last years. (Johansson 2005, 289.)

A categorical–content approach is what is usually meant by ‘content analysis’. It means that categories of the studied topic are defined and the narrative is extracted, classified and gathered into categories. Quantitative treatment of the narrative is quite common. This approach to look for certain themes or content patterns in a narrative has been common in sociology. (Johansson 2005, 289.)

Finally the categorical–form mode of analysis is about stylistic or linguistic questions of defined units of the narrative. A categorical–form analysis might focus on the kind of metaphors the narrator is using or on the use of passive or active form. This type of analysis is common in sociolinguistics. (Johansson 2005, 289.)

Besides content and expression/structure Johansson (2005, 290) adds a third dimension to the model, i.e. the interpersonal relation perspective, which contains both an identity and a relational function.

Depending on which dimension the researcher focuses on, content, expression/structure or interpersonal relation, different questions are put to the data. A content analysis answers questions like: What happens in the story? Which are the characters? What are the relationships between them? Which is the dominant story line? What are the story time and story space? In what setting do the events occur? Which are the explicit and implicit themes? What is the point of the story? Which cultural, political, scientific and religious discourses are articulated in the story? (Johansson 2005, 286.)

An analysis of expression and structure answers questions like: In what order are the events told? How is the story organised, chronologically or thematically? What is the duration and frequency with which events are told? What distance, perspective and voice is used in the presentation? In what tempo or rhythm are the episodes told? What words are used? What grammatical form is used, passive or active? What rhetorical figures are used, e.g. metaphors? What type of plot is there? Is it a comedy or a tragedy? (Johansson 2005, 286.)

The analysis of the interpersonal relations answers questions like: Who is talking to whom, when and where, what is the purpose of the conversations? What kind of relationship is there between the interviewee and the interviewer? What are the differences in social position: gender, class, sexual orientation, age, "race"/ethnicity, knowledge, experience? What is the interplay during the interview? Verbal and non-verbal expression? What conversation styles/communicative strategies are used? Who dominates in the interview? How? When? In what respect? Are there critical points in the interplay, misunderstandings, conflicts? What identities are created in the storytelling? (Johansson 2005, 286-287.)

In her outline of a line-by-line narrative analysis Fraser (2004, 186-196) distinguishes seven phases: (1) hearing the stories and experiencing the interviewee's and the interviewer's emotions, (2) transcribing the material, (3) interpreting individual transcripts, (4) scanning across different domains of experience, (5) linking 'the personal with the political', (6) looking for commonalities and differences among participants, and (7) writing academic narratives about personal stories. This outline can be looked at from a social work perspective.

In social work it is not always possible to record, listen to and transcribe narrative interviews like researchers do, although for example videotaping of interviews could be used more in the work with clients and in supervision. Instead, social workers usually have to listen very carefully to the client's story during the interview and make notes. While listening the social worker needs to distance herself/himself enough from the storytelling to be able to reflect on it while at the same time listening. Fraser points out that emotions of both interviewee and interviewer should be registered, body language observed, agreements and disagreements noted, because they can give insights about how the conversation unfolds. This includes paying attention to the interaction between social worker and client and to the context where the interview takes place. Observing how the interview and the narratives start, unfold and end may be important in understanding what the client wants to say. It may be helpful to go through the interview thoroughly afterwards, to complete notes, and to think over the interview as a whole. (Fraser 2004.)

According to Fraser (2004) the main challenges of interpreting individual interviews is trying to separate long chunks of talk into specific stories or segments of narratives. This may be difficult because one story often ends seamlessly into another. The interviewee may also jump from one subject to another and tell stories that are not separate and complete. Because the interviews are seldom recorded and transcribed it may be easier to try to recall the sets of ideas expressed and the scene(s) in which some sort of plot unfolds. The interview may be analysed from intrapersonal, interpersonal, cultural and structural aspects. Intrapersonal aspects often appear through the client's self-talk, i.e. when the interviewee says "And I said to myself...". Interpersonal aspects appear when the interviewee reports what he/she said and what somebody else said. Cultural aspects again often refer to larger groups of people or to social conventions. Structural aspects often appear when talking about social phenomena, and about class, gender, ethnicity etc. Linking 'the personal with the political' involves looking at how dominant discourses and social conventions constitute an interpretative framework for understanding the stories. Looking for commonalities and differences among participants is particularly important when the social worker wants to advocate for certain groups of clients. By classifying and typologising clients' stories similarities and differences become more visible. Written analyses of the stories of clients form new stories, and we need to be careful to check that these analyses correspond to the stories told whether they are written as scientific articles, for agency files or as social reports. In seeing that narrative analysis offers a way to understand the role personal stories

play in the making of the socio-political world social workers can use this knowledge to reinforce or context dominant social practices. (See Fraser 2004.)

3 THE USE OF BIOGRAPHIES AND NARRATIVES IN SOCIAL WORK

Narrative approaches in social work have been classified as belonging to the ‘third wave’ of social work theory characterised by solution-building and potential rather than by pathology. In this classification the ‘first wave’ is described as a pathology-based medical model building on the ideas of Freud and his successors, and the ‘second wave’ as characterised by problem-solving. (Milner & O’Byrne 2002, 84.) Maybe as a kind of protest against the medical model and pathology-problem-oriented work social workers have often been actively looking away from dealing too much with clients’ past life. Another reason for the unwillingness to dwell on clients’ past may be that many social workers feel they do not have the competence to deal with very traumatic experiences in clients’ past, if such come up. Many social workers have felt that their competence is more solution-oriented, i.e. oriented towards working with the present and the future. This may have lead to neglecting clients’ life histories and life stories. Despite this doubt of many social workers biographical narratives seem to be fairly commonly used in social work. With the concepts of ‘narrative’ and ‘biographical’ many social workers feel they have now got an acceptable term for what they have been doing all along. As mentioned earlier in this module, a narrative is not always the story of a life. It can also be a story about something else, for instance about what happened when the person did not have money to buy medication. The work of social workers very much include listening to clients’ different, biographical as well as other, narrations.

Narratives are used in social work mainly in two ways: First, clients’ biographical narratives can be used as a method to collect information necessary for getting a better understanding of the clients and their social reality. Secondly, biographical narratives can be used as tools in themselves to help clients to change, e.g. in building up their identity, in making new interpretations of their life, in creating a new life story, and in empowering themselves (Nousiainen 2005). This work of change that a person does is sometimes called ‘biographical work’, which is defined by Chamberlayne (2004, 32) as the ‘process of developing more self-understanding as a basis for more reflexive and purposeful strategies’.

Even when a narrative method is used by a social worker just for collecting data, for the client the mere telling of his/her life probably has some interventive effect, too, positive (therapeutic) or negative (disruptive). Rosenthal (2003, 915) finds it impossible to avoid interventions even in open research interviews. What then about narrative interviews in social work, where the interviewee supposedly from the very start has certain expectations of professional intervention?

In social work biographies are usually produced orally but written biographies are also used. Some clients may not be able to narrate long stories without engaging in a dialogue with the listener/social worker. Sometimes pictures and other objects may be used to facilitate a biographical interview. In the following we will look at some of the ways in which narratives, narrated biographies and a biographical approach are used in social work.

3.1 Narrative therapy

One of the best-known ways of using biographies and narratives as tools for change is probably the narrative therapy developed by White & Epston (1990). This is a type of psychotherapy in which the goal is to influence clients' ways of narrating about themselves and their life. If the client is caught in a destructive narrative, the goal is to release him/her from it and create another, more positive narrative. An essential tool is to externalize the problem, so that this can be controlled and worked on through language. Features of this narrative theory are probably used in social work, although maybe not always in a systematic way.

3.2 A narrative approach in social work assessment

Social work usually starts with an assessment as the basis for an intervention plan. If the assessment is seen as an intervention in itself, the choice of approach is not insignificant. Milner & O'Byrne (2002) present different possible approaches in doing assessments, one of which is the narrative one. Narratives are used not only to look at a client's past but they also provide good opportunities to look at the future. Stories can be told, but they can also be retold as alternative stories. The intention in narrative approaches is to address power issues by deconstructing dominant cultural stories which may be marginalising and oppressive. The intention is that service users

themselves make meaning of their lives rather than are entered into stories by others. In a narrative assessment the social worker and the client together reflect on how the client came to be drawn into a 'problem-saturated story'. This is done in a way that separates the problem from the person (externalising conversation). The problem is given a name of its own and the discussion is dealing with the person's relationship with the problem. The language, the choice of questions, is important. (Milner & O'Byrne 2002, 153-154.)

3.3 Narratives in rehabilitation

An introduction to the narrative approach in rehabilitation was given in module A.4. Narratives may have several different roles in rehabilitation. Rehabilitees listen to, live and imagine narratives in order to build a new picture of the past, the present and the future. The narrative a rehabilitee tells the rehabilitation worker is an important tool for mutual understanding. At work places and other organisations collective stories can either further or prevent the goals of rehabilitation. Finally, stories are also present in rehabilitation institutions and among different professions in building up, sometimes competing, model stories for the justification, the realization and the goals of the rehabilitation. (Valkonen 2004, 175.)

A social worker working from a narrative perspective encourages clients to look at their life as if it were a story that can be looked at from different perspectives and the interpretation of which can be changed. A life change causes a break in the life story. Rehabilitation then means consolidating a life story structuring life. This may happen either by the life change being integrated into the previous life story, or by creating a completely new story that makes possible a new interpretation of life. The rehabilitation should support building a story in which the rehabilitee can have a positive idea of himself/herself and his/her life. Model stories of rehabilitation may be a resource to rehabilitees, but they can also restrict and prevent rehabilitees from carrying out necessary changes in their life. Model stories in rehabilitation may restrict professionals, too, so that they have preconceived views of what is the "right" type of rehabilitation. (Valkonen 2004, 176-184.)

Even if a narrative approach can many times be useful, Valkonen (2004) warns for expecting too much from it, e.g. quick and easy solutions to complex questions. There are no short cuts to effective rehabilitation, he says. The important thing is

that the story is created in a dialogue between the rehabilitee and the rehabilitation worker about what has happened, what is the present situation and where to go in the future. (Valkonen 2004, 188-189). Often it is a question of attitude and general approach, where the rehabilitation worker is sensitive to and opening up for biographical reflections.

3.4 Biographies in child protection

Biographical tools may be used in child protective work to help children tell their life stories and find alternative stories for their future. The biographical skills of personnel working in child welfare institutions were enhanced in a project where the personnel was taught artistic ways to express their own life stories. The idea behind the project was that if a child stays out of touch with his/her own experiences and feelings, the risk for exclusion grows. Adults can help children see their experiences, if they themselves are prepared to meet their own history on an emotional level. The information a life story can give has most value to the narrator him/herself. A child may live in a situation, where the story adults tell is very different from his/her own experiences. Developing the child's skills to express his/herself and tell his/her life story to others can be vital in managing life. (Bardy & Känkänen 2005.)

In adoption counselling a biographical approach is often used, when assessing the fitness of persons who want to adopt a child. A couple may be asked to tell about their childhood, their life as a couple etc. Their capacity to reflect on their own life, considered important when adopting a child, gets assessed, too, in the counselling process. (Eriksson 2006).

3.5 Narratives in the care of alcohol and drug abusers

In the care of alcohol and drug abusers narratives are used when discussing the history of the abuse and the role of drugs in a client's life. (See Mikko's case in this module.)

3.6 Biographies in working with the chronically ill and the handicapped

Falling ill with a chronic disease and/or getting a handicap may mean big changes in

daily life. However, the changes are not always stable conditions to which one adapts once and for all. The illness often has a course, which may include a risk for increasing functional difficulties. The dynamic and changing aspects of a chronic disease become more visible, if they are studied from a long-range life-span perspective. (Jeppson Grassman 2001.)

3.7 Biographies in working with the bereaved

Walter (1996) has introduced a model of grief using biography, which may be useful to social workers working with bereaved persons. He challenges the model of seeing grief mainly as a working through of emotion, where the eventual goal is to move on and live without the deceased. Instead he points at the fact that survivors usually want to talk about the deceased with others who knew him/her, and that this is done with the purpose of constructing a story that places the dead person within the lives of the survivors and integrates the memory of the dead person into their lives. In Walter's model talk, in particular meaning conversations with other persons who knew the dead, is seen as more important than feeling. Counselling with professionals is important particularly in cases where the bereaved has no one to share his/her memories with.

3.8 Biographies in working with the elderly

Molander (1999) found that old people facing death can be helped by having someone listening to their life stories and reinforcing the positive aspects of the stories. Studies on reminiscence work in groups of elderly persons showed that the reminiscence work served more as a tool to confirm the value and meaning of the elder persons' life than as a means to regulate their mood (Saarenheimo 1997).

3.9 Narrative peer support

Narratives have long been commonly used in peer groups, both in self-help groups and in groups led by professionals. Sharing stories with persons with the same type of handicap, disease, and life situation can help to see new perspectives and to find alternative narratives as well as to receive and give

support. (Valkonen 2004, 185.) Social workers often conduct peer groups especially in medical settings and in rehabilitation.

Exercise 2.

In what ways have you yourself possibly been using biographies and/or a biographical approach in your work? In what other ways can you envisage using the approach in your own work?

3.10 Documentation

A difficult question for social workers often is how to document biographical interviews. The views on documentation in social work have changed over the years. Historically there are two main streams: the legal-administrative tradition and the psychosocial case-work tradition. The former emphasizes documentation as a means of controlling that interventions are legal and correct. In the psychosocial case-work tradition, process recording of client interviews has long been seen as essential for supervisory and pedagogical purposes. However, in the 1970s this type of documenting was criticised. It was not seen as encouraging an analytical view on the work, and there was a call for more structured documenting in line with seeing social work intervention as mainly a problem-solving process. This also had to do with the requirements of accountability. Newer models for process recording aim at including more reflection. The impact of clients' rights, computer technique and confidentiality on documentation has also been discussed. When developing documentation practices we first have to define the purpose and then consider what kind of documentation best serves this purpose. But the considerations are also influenced by general views on social work. In developing documentation of today we need to think of how the discussions on e.g. reflective professionalism, self-evaluation, evaluation research, and legal and other rights of the clients affect documentation. (Karvinen-Niinikoski & Tapola 2002; Tapola 2003.) This discussion also pertains to documenting life stories and the biographical information clients give us.

In a constructivist perspective language plays an important role in defining and constructing persons (White & Epston 1990; see Milner & O'Byrne 2002, 183), and so what is written down in a person's case file is far from insignificant.

Milner & O'Byrne (2002), who to a high degree rely on White's and Epston's narrative theory, suggest that after an initial assessment the client be given written narrative feedback. The feedback can be written as a letter, which comments on the interviewee's stories. Letters, however, are usually not suitable for agency records. Milner & O'Byrne propose a format of recording that can be used both as feedback to clients and for agency records. It has the titles "Problem", "Unique outcomes", "Thoughts on solutions", "Homework" and "Afterthoughts". The notes are written in a language understandable to the client using his/her own words and metaphors. In the last section the social worker writes down ideas that may be helpful in the following session. (Milner & O'Byrne 2002, 162-165.)

Experiences of co-authoring narratives, i.e. collaborative representation, for medical records have been described by Mann (2001). She started out with asking clients, if there was anything in particular they liked her to record on their behalf. Later she invited them to join her in forming the words and telling the story. She would sit next to the person and ask them where they wanted to begin or what they would like the medical team to know so that the team could be more helpful. In doing so Mann noticed that new conversations developed. The significance of co-authoring for the clients was shown by the fact that some of them wanted to sign the record at the end. The question of confidentiality, of course, is the same here as in other type of recording. In Mann's mind collaborative reporting is a practice of respect. (Mann 2001.)

Exercise 3.

Reflect on documenting your own work considering the views presented above. For instance, would you be able to give written feedback to you client or use collaborative representation in your work?

3.11 Ethical considerations

Nousiainen (2005) points out that biographies should not be used without reason. Social workers need to consider what a biography may or may not add to the work and

before conducting a biographical interview ask themselves: How is it produced? How will it be analysed? For what purpose will the story be used? What kind of knowledge can be gained from the biography? And, of course, a biography should be produced only with the consent of the client. (Nousiainen 2005.)

Social workers may feel they do not have the competence to deal with difficult events in the client's past and are therefore hesitant to do biographical counselling. In social work there are, however, other ways of dealing with clients' biographies than psychotherapy per se. Clients should be told in advance what kind of help they may and what kind they may not expect to receive from the social worker.

Social work clients should be allowed to participate as much as possible in all interpretation and analysis of their life stories; the value of biographies does lie in the meaning they have for the persons themselves. Milner & O'Byrne (2002, 155) mention Payne's (2000) notion that externalisation adds to an ethical way of working, since it makes the process transparent as the service user can hear what the social worker is saying.

The more professionals know about a client's life the greater the demand for confidentiality. This pertains especially to documentation, which gives the social worker great power to define the client. Who actually owns the story of the client is a question, which could well more often be discussed with the client.

Kyllönen (2004) discusses how social workers' biographical constructions of their clients may affect the social welfare interventions. She points at the power of social workers in a welfare policy framework to produce "normal" biographies rejecting alternative biographical destinies. Welfare programmes and professional practices in this case serve as strategies of normalisation. (Kyllönen 2004, 247-248.) The social workers in Kyllönen's study obviously had not conducted systematic extensive biographical interviews with their clients. However, the question remains as to what extent the general policy and regulations of a social welfare office allows for supporting biographies that differ from the "normal" ones.

Milner & O'Byrne (2002) seem to think that the narrative approach can be used with clients with any kind of problem as well as with clients with for instance limited intellectual capacity or a major mental illness. As a possible disadvantage they mention the fact that a narrative assessment can be more intrusive than a more structured approach, because it takes longer to conduct. Also using clients' own language may collude with male metaphors of control. (Milner & O'Byrne 2002, 166-168.)

Exercise 4.

What ethical dilemmas can you find in your own work using biographies and a biographical approach?

4 SOCIAL WORK CASE ANALYSIS: THE CASE OF MIKKO

A social work student (Levälahti 2005) conducted a study for her Master's thesis, in which she interviewed eleven former alcoholics about their recovery process. Her generating question for the interviews was: "Could you, please, tell me about your life? You can start anywhere you want." The analysis of the interviews focused on the role the social network played in the recovery process. A categorical–content approach was chosen (see the model for the classification of types of narrative analysis developed by Lieblich et al 1998; figure 1 in this module). In the life stories three phases were distinguished: the addiction, the turning point and the recovery process. The social networks of the interviewees were categorised as being informal, formal or due to cohesion, and the support they received as emotional, instrumental, informational, or existential. The support could be either positive or negative. In addition to these interviews, the social work student later conducted a focus group interview with social workers discussing the use of biographies.

In this chapter the student presents and discusses an interview with a former alcoholic (Mikko) as an example of individual biographical work in a recovery process. She also presents a part of the focus group interview which dealt with Mikko's case. The case provided material for a discussion about how biographies can be used as a tool in social work. In writing about the interviewees' experiences and the focus group discussion the student is creating her own narrative.

4.1 Biographical work in Mikko's change process

Mikko had been an alcohol addict during almost 40 years, and his problem had been quite severe for about 10–20 years. The problem got worse and became more visible in course of time. Most of the time of addiction Mikko lived with his family and they experienced difficulties caused by his drinking. Mikko experienced negative impact from his informal network, as lack of relations. When Mikko's wife suddenly died, he

had to take care of their youngest child. That meant a kind of support for Mikko, even if the task was not easy to handle:

“The youngest child was then 14 years and I felt like a tower block of responsibility and problems fell upon me ... If the youngest child had not stayed at home, I had probably let everything go, not bothered about anything...”(M/389)

Granfield’s & Cloud’s (2001, 1554–1566) study indicates that responsibility towards others can be a resource in the recovery process.

In a while Mikko found a new partner and they moved together. Mikko’s drinking continued and his family had him choose between them or the spirits. Mikko chose to continue drinking. However, Mikko’s informal network provided instrumental and informational support by taking him to the hospital and making appointments with a psychologist. They also informed him about a Minnesota-treatment.

During addiction Mikko seemed to do quite a little amount of biographical work. Life events that shaped his life happened, but he did not reflect upon them. One of the first times biographical work appeared in Mikko’s story was when he attended an Alcoholic Anonymous meeting. There he listened to the stories of others and also reflected upon his own life, even if the context felt somewhat strange to him. In AA he experienced acceptance, even though he knew that he had spoiled a lot of things in his life because of the drinking. No one condemned him for being an alcoholic and that accepting treatment became an emotional support.

“...it felt good, already then I liked to be there, no one condemned me for being an alcoholic, I thought that no one would have denied me to go to Alko² afterwards...”(M/404)

Mikko also had contacts with the health care system during addiction. According to Mikko professionals were unwilling to talk about the addiction. Either they did not have enough knowledge or understanding about alcohol matters or they did not allow him to express his worries about his drinking, which meant negative impact on him. One professional, though, encouraged his plans for the future, and professionals could provide instrumental support through care and medication. For Mikko it was, however, a problem that he got too much habit-forming medication.

2 Alko is a trading chain, specializing in alcohol beverages, owned by the Finnish State, and administered and supervised by the Ministry for Social Affairs and Health.

The turning point came when Mikko tried to commit suicide, but failed. Mikko's grown-up child brought him to the hospital and the turning point arose when his family came to see him in the hospital. He realised that the family was more important than the drinking.

Mikko's turning point was strongly connected to his informal network. The formal network took care of Mikko in the hospital and provided him with instrumental and informational support, but he did not mention them in the interview as being part of his turning point. After trying to commit suicide, Mikko lied unconscious in the hospital. When he woke up he noticed that he was surrounded by his family, and he realized that he had to quit drinking, if he wanted to hold on to his family.

"... I woke up and all I could see was the whole family there and, when I woke up before that, then I dropped off again, then I thought that I failed with this too, but then when I woke up the second time and saw the family, then actually I had thoughts about doing something about my drinking ..." (M/403)

For Mikko this meant a lot of emotional support, which was crucial for his recovery from addiction. Afterwards Mikko was able to reflect over the turning point and his time of drinking.

"..I never thought about what I did to my children and my partner, what problems I could have caused them, I did not think about that at all, I only thought about myself ..." (M/402)

Although Mikko realized that he had to do something about his drinking he was at first not ready to seek institutional treatment. Luckily for Mikko his family had arranged treatment for him in a Minnesota programme, and they more or less forced him to go there, which meant both emotional and instrumental support.

During the turning point Mikko seemed to do more conscious biographical work. He reflected upon the price he had paid for drinking. He had once deliberately chosen spirits prior to his family. In a biographical perspective one can assume that this had happened indirectly several times while he was living with his family. Drinking had often gone prior to other areas of responsibility.

The month in the Minnesota treatment was intense. Mikko realized that the other patients were ordinary people like him, and they became part of Mikko's recovery. Mikko described the change process as follows:

“I thought that I cannot stop drinking, and I do not even want to quit, but it was strange, when you listened, you were not allowed to do anything there ... everything circled around thinking about yourself... and when you had nothing else to do, were in therapy from morning until evening, and discussed and listened to others discussions, and little by little, it became understandable, for me too...”(M/409–410)

Mikko’s change process included therapy, own reflections and listening to and discussing with others. All factors in the process contributed to the biographical work Mikko was doing during the treatment. During treatment patients were not allowed to do any unnecessary work, which meant that there was a lot of time and space to reflect on the lived life and on future possibilities.

In treatment Mikko also had to face what he had done to his partner and children. He was confronted with the family and their experiences of his drinking.

“... I thought that my children could not say anything about me, but, they told me all I had done to them, and I am glad that they did, because, everything was true, it was not something they lied about, but I had not thought of it that way”(M/411)

To learn about his family’s experiences during his years as an addict gave Mikko a broader perspective on life, and also made it possible for the family members to start all over again. Although this was a tough experience, sorting things out provided good emotional support.

According to Mikko, his family confirmed the biographical work he was doing during the treatment, now they treat him with more respect and more confidence. The family accepts his new identity as a former addict, and also confirms his new way of telling his life story, as a story where he has succeeded in overcoming addiction. During the treatment both Mikko and his family got informational support from the treatment setting. There alcoholism was regarded as a disease, and this helped them to explain the past and create a new story.

Back in everyday life Mikko was at first uncertain of how his old friends would react. He still avoids his drinking friends, but do tell other people his life story if asked. Mikko has started to attend AA meetings and thereby he has got something to do and also new friends, e.g. both instrumental and emotional support. He also feels good, when he sees that he can help others, by telling them his own story.

An important part of Mikko's change process including the biographical work was a social network due to cohesion. Once a week, during the first year after treatment, Mikko and his partner met with others who had undergone the same treatment.

"...and it was good, I willingly went there, and it was, you looked forward to it, to meet all the friends... it was a good step, to cope with, to be able to succeed and be strong in these trains of thought, and so, you do not want, my sobriety has lasted for two years and I do not always think about spirits any more.. of course you take one day at a time, but I do not have that craving..." (M/414–415)

Vilma Hänninen's (Hänninen & Koski-Jännes 2002, 19–23) concept of "the inner narrative", which means the subjective experience and interpretation of life, includes three levels. The "original" narrative works as a matter of routine, while the "reflective" narrative is needed when the original narrative does not work. The third kind of narrative is "meta-reflective", which means working with the inner narrative as if it was apart from reality. All kinds of inner narratives are influenced by the surrounding cultural narrative, and have an impact on the behaviour of the individual. It seems that a change process from alcohol addiction to sobriety includes more or less "reflective" and "meta-reflective" inner narratives. If the individual does not reflect on his or her own biographical experience or inner narrative, and the "original" inner narrative dominates, change will probably not occur.

In Mikko's life experience the consequences of his drinking cumulated until finally at the turning point he was prepared to begin to do some biographical work. However, it is important to notice that, without the support of his social network Mikko's biographical work may have remained undone. Life experiences, social networks, inner processes and also existential questions cooperate in a complex way in the change process from alcohol addiction to sobriety.

4.2 Social workers' views on the use of biographies

In a focus group interview in August 2005, three social workers who met alcohol addicts in their daily work were questioned about life stories as a perspective in social work. Two of the professionals worked in social services, while the third one worked in an open care setting for addicts. All social workers had mostly adult clients. One of the topics discussed in the focus group was: Life stories in social work and the case of Mikko.

The social workers pointed out that each one of them worked on the basis of their main tasks. Depending on their main task, and the client's need they start to explore the actual case. The social workers do not encourage their clients to tell about their whole life but do want to get an overall picture of the client's situation.

Social worker #2#: *"Of course you have to map out the situation, how it is, and you ask a lot of questions and get a, at least I like to have some background information ... to know something about the client, although it is only about getting financial support ... but people are different, some tell you their story, also new clients, they tell you everything"*

During his talk one social worker notices that despite that he has not thought biographically, the clients' life history became present in investigating different kinds of accommodations in the clients' life.

Social worker #1#: *"I have not gone so far (to the childhood / JL) ... when I worked with homeless people I was most interested in their accommodation history, where they have lived, types of accommodations they have experienced, and by that there came some history, or I tried to form an opinion about in which kind of accommodation they would manage to stay, and to take care of themselves, not too big challenges ... by that they told about where they geographically had lived and when and where they worked and so on..."*

The third social worker, who worked in open care with addicts, was more aware of her bringing life stories into her daily work. In meeting with new clients she had a period, four or five sessions, when she explored the situation. During this period the social worker made an alcohol case history.

Social worker #3#: *"Our starting point is the addiction problem and we make this alcohol anamnesis, back in time and in relation to that ... we go through this, how the problem started and developed during the years ... and in this the individual's life story will be present ... and if the person continues in therapy, we will go back to and build on the story, it is an important instrument in my daily work"*

The social workers do think that biographical work is an important part of a changing process, but all clients do not want to change or do not think that they need a life change. They just want financial help or immediate help with their current problem. One social worker expressed that biographical work often is not done at all, if there is not an ongoing change process. In a rehabilitation situation the most important task is to be able to activate the client and the central precondition for this is to get the client to do biographical work. The past also determines which future possibilities the client has, and an understanding of the client's life may help the social worker to give more adequate advice.

One social worker also thought that there are at least two groups of addictive clients. Some young addicts may not have a sober life story at all, because they started their addictive life style so young. In that case the social worker finds it hard to work biographically. The addicts are rootless and there have been no or few resources in the past. The life story perspective is easier to accomplish with addicts who have lived a sober life before they started their addict life style. In these cases the social worker finds it easier to go back and point out resources in re-creating a sober life style. Although the point of view is understandable, it might be questioned, whether biographical work might be even more needed and fruitful with clients who have no sober life story. To create a life story with rootless clients may help them to get a base to build their future on. Although most of their life consists of addiction, having come to a care setting indicates that they do want some kind of change. Finding one's own biography may also include going back to previous generations, identity work, future dreams and expectations of life.

In the discussion the social workers pointed out that change is a process that takes time and has to be allowed to do so. Since social workers' instrumental support can be an important means of supporting a client, they should be allowed to concentrate on the change process.

During the focus group interview the social workers were asked to comment on Mikko's case. They found it hard, because the description of the case was brief. The social workers were familiar with the kind of life story that Mikko told, and commented that stories seldom have the happy end that Mikko's story had.

One worker said that it is hard to do anything about a client's drinking before the client is ready to change. The consequences of the addiction have to be visible to the

client, and the client has to experience no more positive effects of drinking. The client's personal motivation was seen as decisive; if the client had no motivation for change, no kind of support was of any use.

The case also resulted in a discussion about Alcoholic Anonymous and the need for different kinds of treatment settings. Clients have different needs and use for different treatments. What works for one may not work for another. One social worker also pointed out that the same client might need different kinds of support and that professional and mutual support can be supplementary. Mutual support groups can also offer friendship and alternatives to drinking.

One social worker commented that although there are common patterns for most addicts, there is always also a personal touch to the problem that comes from the life story. The starting point has to be the client's situation, and that is one factor that increases her interest in her daily work.

Social worker #3#: "but I think that there are those small stairs ... the background, all that happened influences the process ... behind the process there is a course of events that leads to a lasting change".

In the focus group interview with the social workers one interesting observation was that although they all saw life biography and life history as an important part of the change process, there were few comments on the life events and their impact on the process in Mikko's life. Social workers seem to concentrate their work on their main practical tasks, and if biographies happen to be part of that work, social workers welcome the biographical approach, but they do not seem to work deliberately with "biographical glasses" on.

5 CONCLUSIONS

In this module we have tried to show that biographies, narratives, and a biographical approach can be useful and appropriate tools in social work. However, they should be used with discretion and awareness of their limitations.

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V A social work perspective on the biographical research interview with Natalia¹

Johanna Björkenheim

Abstract

Biographical interviewing is used not only in research but also in clinical work such as social work practice. However, as social work settings differ from research settings, the ways of doing, analyzing and using biographical interviews will differ. The differences arise from the reasons for and the purposes of the interview, the institutional context, the relationship between interviewer and interviewee, interviewees' capacity for storytelling and reflective work, time limits, the structure of the biographical interview and follow-up interviewing. In social work, interviewees are in a more vulnerable position than in research, and there is a stronger power imbalance. The service users' expectations are essential for the work, and it is important that the users articulate their expectations, because the purpose of social work is to change and improve the life situation of service users. This asks for ethical considerations that are partly different from those necessary in research.

The biographical interview with Natalia is here analyzed using the strengths perspective as the social work theoretical framework. The analysis shows that in her present life Natalia has many strengths and resources which, in a social work situation, could be mobilized to support her in getting more control over her life. Her perceived strengths are: her capacity for storytelling and reflection; her emotional and cognitive capacities; her willpower; and her capacity for enjoying her present life and planning for her future. Resources identified are: her significant others; her economic situation; her satisfying job situation; her capacity to have dreams for the future; and her religion. Implications for social work both in the past and in the present are discussed.

Key words: Social work, Biography, Strengths, Interaction, Ethics, Interview

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Biography and social work

The purpose of this article is to analyse a given biographical research interview from a 'social work perspective', and there are a number of possible approaches to that. My own perspective is grounded in lengthy experience of social work practice in health care and rehabilitation, as well as in theoretical studies on biographical methods carried out largely within the EU Leonardo INVITE project² (Björkenheim & Karvinen-Niinikoski 2009a; Björkenheim & Karvinen-Niinikoski 2009b; Björkenheim et al 2009) and subsequently (e.g. Björkenheim 2010). These experiences lead me to believe that biographical methods do have a place in social work practice, at least in certain contexts and with certain service users.

In addition to analysing the empirical interview data, it is necessary to discuss some general differences between research and social work practice as settings for biographical interviewing. Biographical researchers have found that "unhampered autobiographical storytelling is basic biographical work" (Schütze 2009:23) and that it can have healing effects (Rosenthal 2003). However, some researchers have questioned the use of biographical methods for "informal therapy as a by-product" (Richard 2004:171) and the claims for empowerment through biographical research (Bornat & Walmsley 2004). In my view, practice and research are essentially different as settings for biographical interviewing and this implies different considerations in the use of biographical interviewing (Schütze 2009). One of the main characteristics of social work practice is that it generally aims at change and improvement in the lives of the service users³, whereas the aim of qualitative interviews for research - except for different types of action research - is generally not primarily to bring about change in an interviewee's situation.

2 The project EU Leonardo INVITE 2003-2006 developed a curriculum for teaching 'biographical counselling' to professionals working in vocational rehabilitation (European Studies on Inequalities and Social Cohesion 1-2/2008 and 3-4/2008). The participating universities were those of Magdeburg in Germany, Helsinki in Finland, Wales/Bangor in UK, and Łódź in Poland. Practice institutions in these countries and in Austria and Italy participated as well.

3 The definition of social work last adopted by the International Federation of Social Workers (IFSW) and the International Association of Schools of Social Work (IASSW) states: "The social work profession promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance well-being. Utilising theories of human behavior and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work." (IFSW 2012.)

Biographical interviewing may be used not only in social casework but also, for instance, in psychotherapy (Hornung 2010). It is important to note that, whilst social work practitioners may use biographical approaches and their work will often have therapeutic elements, social work is not psychotherapy. Psychotherapists generally focus exclusively on psychological and relationship issues, whereas social workers will typically be involved in practical matters as well (Wilson et al 2011:347).

In many respects the interview with Natalia resembles interviews I used to carry out as a social worker with service users in a rehab unit, where an inter-professional rehabilitation team assessed users' employment capacity and opportunities for rehabilitative interventions and in collaboration with the users made plans for their future. A main difference here, of course, is that Natalia is not presenting the interviewer with any explicit problem she needs help with, particularly not a problem related to her work or employment capacity. But the question remains: If Natalia was telling her story to a social worker, how might the worker listen and react? In what way would that be different from a researcher's way of listening and reacting?

In my analysis of the transcribed interview with Natalia I have focused on two aspects: first, the interaction between interviewer and interviewee, including Natalia's possible motives for wanting to participate in the interview, and second, Natalia's story analysed using a strengths perspective (Saleebey 1997) as the theoretical framework. In the conclusion I discuss possible implications of Natalia's story for social work practice.

Social work intervening "at the points where people interact with their environments" (IFSW 2012) implies that social work is context-bound. My own context is Finland, a Northern country of 5 million people, where a welfare system was built up after World War II. During the past twenty years welfare services have been cut resulting in growing socio-economic differences. The education required for qualified social workers in Finland is a Master's degree in social work, comprising five years of university studies. Most social workers in Finland are employed in the public welfare services, mostly in social services, but also in public health care and in state schools.

There are some obvious risks in applying a social work perspective to a biographical interview performed in another national context. However, I believe that there are common features in the ways social workers, at least in Western countries, relate to their profession and to service users, and an outside perspective may at best generate some new thoughts on the subject.

Before going into the analysis of the interview, I will make some reflections on the differences between social work practice and research in regards to biographical interviewing.

How do social work interviews differ from research interviews?

As mentioned before, I find it necessary to distinguish clearly between social work practice and research as settings for biographical interviewing. Comparing the two settings, at least seven main differences are identified:

First: the reason for and the purpose of the interview. In social work the reason for an interview is usually the service user's problematic situation, and the purpose is to enable the service user to get some help with his or her situation and achieve change. In a research interview, the research itself is usually the reason for the interview, and the purpose is for the researcher to get a 'good interview', i.e. good research data; the purpose is not to create change in the particular interviewee's life situation.

Second: the institutional context. Social workers generally work in institutions (public or private) which set the terms for what services they can offer to service users, and how. The institutional context probably also restricts the narrator's free storytelling in different ways, especially if the social worker can influence the provision of services (Schütze 2009). Researchers do not typically offer any services and the institutional frames are different, even if not necessarily less strict.

Third: the relationship between interviewer and interviewee. In social work practice the interviewer is a professional who is educated to work with service users on improving their life situation. Service users usually see a social worker because they have a problem. They are therefore generally in a more vulnerable position than research interviewees. They have to make their situation understood and convince the social worker of their needs. The social worker generally represents a public authority with power to influence the provision of services, which implies a considerable power imbalance in the relationship. In biographical research the interviewing relationship is different, even though there is usually a power imbalance there, too (Kaźmierska 2004). Research interviewees generally volunteer to be interviewed and, as a rule, are not dependent on the interviewer for any service they need. On the other hand, the relationship between researcher/interviewer and research subject/narrator may be more

difficult in the sense that it is more unclear. The researcher becomes a character in the story of the research subject and thus changes it (Shaw 2008).

In biographical interviewing the relationship between interviewer and interviewee is different from many other interviewing relationships also due to factors such as time and confidence required. Sometimes this particular constellation may raise expectations of help that the interviewer, whether social worker or researcher, is not capable of meeting, especially when it comes to handling early traumatic experiences. On the other hand, professional social workers may be better equipped to deal with such expectations and have better knowledge of available services than do researchers.

Fourth: the interviewee's capacity for storytelling. Persons with little capacity for storytelling would hardly volunteer for a biographical research interview, but they might well be service users in social work. Biographical narrative interviewing is therefore not always possible in social work.

Fifth: time limits. In a social work situation, there are generally quite strict time limits both for the interview and for the work to be done before and after the interview. A biographical researcher supposedly has more time to plan, perform and analyze his or her interviews. The biographical research interview with Natalia took three hours. In the rehab unit the social worker usually has two hours for an assessment interview including a dialogue on the user's expectations and on available rehabilitation services. In most other social work settings there is not that much time available for one interview.

Sixth: the structure of the biographical interview. In research an autobiographical narrative interview is generally as open as possible (Schütze 2009). Because of the specific characteristics of the social work setting, biographical interviews often have to be more structured along certain themes and include more verbal dialogue. There is also more direct questioning about facts, and certain issues have to be discussed, either they are brought up by the service user or not.

Seventh: follow-up with the interviewee. In research there is hardly much follow-up with interviewees for the sake of the interviewee as a person. In social work a biographical interview used for assessment is often just the beginning of the work. This means that, if necessary, there will be opportunities later to deal with strong emotions and issues provoked by the narrator's biographical work.

The characteristics of social work practice have certain ethical implications. A social worker must consider for what purpose a service user is asked to tell his or her life story. And how will the story be interpreted and used? And by whom? How will the life-story telling contribute to the improvement of the user's life situation? In research, there is no obligation to improve the situation of the interviewee; ethical principles just state that you should avoid doing harm. Since life events and the autobiographical story are essentially meaningful only in the life of the narrator/service user, in social work the user's own interpretation of the story should be given priority (Barker 2009). In research, life stories are interpreted mainly by the researcher.

In research, interviewees will be asked for informed consent. Service users of social work should also be asked in one way or another for (oral) consent to telling their life story (instead of just answering questions about biographical facts), and they should also be given the opportunity to refuse. The question of informed consent to life-story telling seems particularly crucial in settings where social work, in addition to a supportive role, also has a function of control, such as in child protection and social assistance services. The best way to inform a service user of the purpose and possible consequences of a biographical narrative interview has to be determined in each specific case. This difficulty is being discussed in qualitative research too (Shaw 2008).

An important outcome of biographical interviews, intended or unintended and regardless of setting, is the biographical work done by the narrator (Rosenthal 2003; Schütze 2009). This can be quite hard work and evoke strong emotions, as is evidently the case in the interview with Natalia. Persons seeking therapy are generally prepared in advance to work psychologically with their self and their life. Service users in social work (nor research interviewees) seldom know in advance what hard (biographical) work may be involved in a biographical interview. Should they in some way be told about this probable outcome of the interview in connection with being asked to consent to a biographical interview?

In biographical interviewing, where a lot of details are revealed, strict confidentiality is, of course, indispensable. Social workers need to consider how much of users' biographical information actually has to be documented in the files. Confidentiality is obvious in supervision situations, but what about 'informal' supervision between colleagues? Confidentiality is required in research as well but is handled in partly different ways.

Interaction between interviewer and interviewee

Just as the interaction between interviewer and interviewee in research is seen to be an essential element in retrieving good interview data (Lillrank 2012), in most social work theory the interaction and a trusting relationship between social worker and service user are considered essential elements in the helping process (Payne 2005; Wilson et al 2012). In social work, the relationship can even be 'the end in itself', not only a 'means to an end' (Network for Psycho-Social Policy and Practice 2002 as cited in Wilson et al 2011:9). That of course echoes the claims of classic 'Rogerian' person-centred counselling which has been identified as having a particular affinity with the techniques and methodology of the biographical research interviewer (Barker 2009).

In the interview with Natalia, the interviewer very soon manages to build trust in the relationship and shows Natalia that she is actively and attentively listening to her story. As a result, Natalia very soon opens up about her traumatic childhood experiences. The interviewer gives short empathic comments to Natalia's emotionally strenuous story but seems somewhat unprepared for, almost embarrassed at, the strong emotions evoked in Natalia recalling her life before entering the children's home at the age of 15. The interviewer at several points interrupts Natalia trying to make her talk more about the time she spent in the children's home (which is the topic of the research).

In social work, too, for various reasons the interviewer sometimes has to interrupt the narrator's storytelling and try to direct the interview towards issues seemingly more relevant to the purpose of the meeting. This is why social workers have to carefully consider when, why and how biographical interviewing is proposed and introduced to a service user. In social work interviewing strong emotions are not rare taken that service users often are in a difficult life situation and/or have traumatic experiences. If a user seems to need psychological services, the worker can discuss this with the person and explore the possibilities for such services. Social workers themselves should ideally, after critical interviews, have the opportunity to receive supervision or at least some kind of debriefing. Biographical research interviewers may not always have this opportunity. The emotional labour research interviewers may endure is receiving increasing attention (Lillrank 2012).

Natalia's trusting relationship with the interviewer encourages her to talk more and more, almost as if her story had been there long before the interview, just waiting to be told. But is it the story the researcher wants to hear? How does Natalia feel after the

interview? These questions call for some reflections on Natalia's possible motives for wanting to be interviewed.

In the presentation of the interview with Natalia we are told that she volunteered for the interview, because she "wanted to show the fate of a person brought up in a children's home". One can ponder on her possible deeper motives. Natalia may have had other, unarticulated, not even conscious, motives and expectations, when volunteering to participate in the research interview.

In a social work situation, it would be natural to ask the service user directly about her motives and expectations. In this instance, however, we can only venture some guesses. At several instances Natalia points out how lucky she was to be placed in a good children's home. Perhaps by volunteering for the interview she wants to show her gratitude to those who made this possible, to repay in some way for having been 'saved' to experience a 'normal' adulthood? Natalia is emotionally very moved when she talks about her family of origin. Even if talking about her childhood is extremely strenuous, the telling seems to be very important for her. To whom is she telling her story? Is she perhaps telling it to herself in order to better understand who she is and what actually happened to her and her family? Natalia expresses feelings of guilt for having been more fortunate than her siblings and shows grief and worry for them. Is she perhaps telling her story to someone who could confirm to her that she has done everything possible to help her sisters and brothers, and that she needs not feel any guilt?

Natalia tells the interviewer that she now has a good and 'normal' life: that she is happy with her husband and her 13-year-old daughter. However, she is not able to fully enjoy her present life because of her worries about her relatives. Did Natalia perhaps volunteer for the interview hoping that somehow someone would give her the permission to finally enjoy her own life and take care of herself? Natalia talks in detail of her present worries about her relatives: she takes care of her mother, grandmother and nieces and tries to help her siblings in any way she can think of. Is Natalia perhaps telling her story hoping to receive some practical advice to help her in her everyday life? A social worker could have confirmed Natalia's right to take care of herself and helped her to find out what services, if any, might be available to ease her daily burden.

A strengths perspective on Natalia's story

The biographical interview with Natalia would enable a social work interviewer to get a better understanding of her past and present situation. However, in social work, understanding is seldom enough. Showing up in a rehab unit, for instance, Natalia would expect to receive some counselling and practical advice to help her deal with her vocational problem (if she had one). However, the biographical interview could well be part of an assessment forming the base for making a rehabilitation plan for her.

Even though social workers sometimes work according to a selected theory, they have been found mostly to use theory in an eclectic way (Payne 2005). Any of the following theories would probably work fairly well with biographical interviewing: the psychodynamic theory, the postmodern (narrative) theory, the relationship-based theory, the humanistic theory, or the strengths perspective. For my analysis of the interview I have chosen the strengths perspective, which has been fairly commonly used (in a selected or eclectic way) in social work practice in Finland. Dennis Saleebey (1997), one of the main theoretical developers of the strengths perspective, makes a connection between strengths and narrative as follows: "one of the genuine strengths of people(s) lies in the fabric of narrative and story in the culture and in the family" (p. 243). The critique against the strengths perspective focuses on the risk of too much stressing self-help and self-responsibility and underestimating structural inequalities (Gray 2011). However, Saleebey (1997) sees the strengths perspective as "the work of helping clients and communities build something of lasting value from the materials and capital within and around them" (p. 233), not as denying individual and structural problems.

Even though the focus in the strengths perspective is mainly on the strengths of the service user, the guidelines suggest that at the beginning of an assessment a brief summary of the identified problem situation be made and agreed upon (Cowger & Snively 2002). In social work, dialogue is essential, and the difficulty here is that my analysis of the interview can only be based on the transcript without any chance of further interaction with Natalia. Therefore I present Natalia's problem situation as a summary of what appears to me to be her own understanding of her life and present life situation:

Natalia has survived a hard life and is now able to live what she considers a 'normal' life. Her survival is due partly to good luck but also to her own

will and efforts. She feels guilt for her brothers and sisters not having been as lucky as she has. All her five siblings have had and still have unstable lives being, or having been, involved in criminal acts and/or drug abuse accompanied by unemployment and economic misery. However, Natalia wants to think that the bad luck and unhappy fate of her siblings is not her fault. She wants to believe that she has done everything possible to help her siblings. She also implies that possibly her siblings could themselves have made a little more effort to get a better life. She does not judge her parents but tries to understand their situation. In addition to individual reasons, she also sees structural reasons for her family's misery. Natalia has seen it as her responsibility to be the strong one and to take care of the other family members, and they in turn seem to have expected this from her. In this task her suicide attempt at the age of 14 appears to her a big failure, an expression of her weakness. In her present situation Natalia still feels responsible for her siblings and tries to help them and their children. However, some ambiguity can be sensed in her story: How much must she still sacrifice of her time and energy to help her relatives, and how much can she allow herself to enjoy her own life and devote her time on her own little family? Natalia gives the impression that she is quite exhausted (she says that she is "worn out"), and she seems to long for a break in her continuous responsibility, worry and grief over her relatives.

A social worker listening to Natalia's story from a strengths perspective would try to identify personal strengths and external resources that could be supported and mobilized to help Natalia to get more control of her life. In a real social work situation, the assessment would be done in verbal dialogue with the service user. In the transcription of the interview with Natalia at least five essential strengths stand out:

First, Natalia is capable of telling her story and of reflecting on her past, on past events, on persons in her childhood and on herself as a child and as an adult. This means that she is capable of doing biographical work, a prerequisite for a person actively to make changes in her life.

Second, Natalia's emotional capacities seem to be strong and multidimensional; in spite of her very difficult childhood, she is able to appreciate positive things as well. She is not too embittered but is able to forgive and still love her parents. She is able to feel grief and compassion for her brothers and sisters and still takes responsibility for all

her close relatives. She is also emotionally capable of maintaining a relationship with a partner and of mothering a child.

Third, Natalia has considerable cognitive capacities: she has wanted to study and learn new things; she has studied in several schools and even taken a university exam (Bachelor).

Fourth, Natalia has strong willpower and has made several important decisions in her life. One of her biggest decisions was after her suicide attempt, when she decided she wanted to go to a children's home instead of going home, even if that meant breaking with her family. On the other hand, the fact that the family turned their back on her may have enabled her to free herself from them and see herself as a separate person, someone who has to take responsibility for her own life.

Fifth, in spite of all her misfortunes, her unhappy childhood, grief and worries, Natalia has the capacity to enjoy life and plan for her future. She has built herself a new life with a family of her own.

All these capacities of Natalia's are essential strengths, which a social worker could try to reinforce and draw upon to support Natalia to gain more control over her present life. In spite of the difficult circumstances during her childhood, Natalia also had some external resources to draw on. There seems to have been a few people who were crucial in leading her life in a more positive direction. There was her grandmother, who intervened at some critical moments, as when the children set a fire in the home. There was the school psychologist, who helped Natalia to get into the children's home, and there were the carers at the children's home, who showed her what a 'normal' life and 'normal' relationships can be.

In her present life, Natalia also has some external resources to draw upon. Her resource persons are of course her husband and daughter and her friends but also her mother, who now serves as a resource to Natalia's daughter. Natalia's economic situation appears to be sound. She has had a fairly good career and likes her present job. The family has a plot for recreation and has been able to make some vacation trips. The family also has dreams for the future, such as building a house of their own. A resource for Natalia is definitely her religion, even though she seldom goes to church. In a social work situation the worker would also be a resource to the service user, someone with whom to talk and discuss opportunities for help and support.

In a strengths-based social work assessment of Natalia's present situation, the biographical interview would be analysed as a joint activity, and there would be a mutual agreement on the assessment as a base for planning further intervention. In future meetings Natalia's strengths and resources could be further explored and supported, aiming at helping her to gain more control over her life situation.

To conclude

As discussed above, there are both similarities and differences between research and social work practice as settings for biographical interviewing. The relationship and interaction between interviewer and interviewee are crucial in both settings, and many necessary ethical considerations are the same. The main differences pertain to the purpose of the interview, the institutional context, the quality of the relationship between interviewer and interviewee, narrators' capacity for storytelling, time limits, the structure of the interview and the follow-up. In social work the focus is on the service user's wellbeing, whereas in research the focus is on the story itself and its content (the research data). In social casework, the interviewee is generally more vulnerable than in research.

The biographical interview with Natalia raises reflections on possible implications for social work interventions. Could social services have done more to help Natalia and her siblings during their childhood? Societal, judicial and cultural differences, of course, make it difficult for a foreigner to judge this. Moreover, even with strict laws and good protective intentions, child protection is an extremely demanding field of social work. In retrospect, one might argue that child protection authorities probably should have intervened earlier in Natalia's family, as the children were badly neglected long before they were taken into care. But then we do not actually know exactly how and to what extent family services had already been involved. Health care too should probably have been involved earlier, thus maybe saving the 2-year-old sister, who died due to lack of adequate health care in front of her siblings, who had been left alone at home. Natalia states that she made her suicide attempt because she did not know whom to turn to in despair, and perhaps social services would ideally have served as a secure haven for the children to turn to in times of extreme confusion and danger.

When the children finally were taken into care, they were placed in different children's homes. Why they could not be placed together in the same home remains unclear. Maybe it was just practically impossible to let them stay together, even if it appears rather cruel to separate them at such a critical moment. We do not know how much the school was involved in the case, but evidently there was some kind of involvement since the school psychologist intervened after Natalia's suicide attempt.

From a social work perspective, Natalia, in her present life, might benefit from social work support in finding out how she wants to live her life and how she can manage it without feeling that she is neglecting her relatives. Doing what is 'right' seems very important to her. The possibility of getting any kind of help from her siblings or receiving help from social services in the care of the mother and grandmother could be discussed with Natalia. It seems that the child protection services and the counselling, drug clinic, and/or vocational services offered to the siblings of Natalia so far have proved rather fruitless. With her consent and that of her siblings perhaps Natalia's social worker could collaborate with their social workers to work jointly on the complex family situation. Finally, it seems that Natalia herself might benefit from some kind of psychotherapy or from further counselling with a social worker. Natalia does not mention so far having undergone any psychotherapy.

The biographical interview with Natalia seems to lend itself quite easily to an analysis from a social work perspective. Maybe one reason for this is that Natalia has actually been a client of social services and that stories of a traumatic childhood, like hers, are not rare in social work practice. Unlike many storytellers in social work, however, Natalia is extremely reflective and articulate, so that, even without the possibility of further dialogue with her, the reader of the transcribed interview gets a fairly good picture of her earlier life, as well as of her present situation. A strengths-based analysis of the interview shows that Natalia has many strengths and resources. This is, of course, largely due to Natalia's fairly stable life situation at the time of the interview. The life stories of actual service users in social work can be much darker and more chaotic with possible strengths less visible. It would be interesting to read biographical interviews with Natalia's siblings as well, if that was feasible. They would probably be very different.

As mentioned earlier, this analysis of the interview with Natalia was made in a different social and cultural context than the one where the interview was done and the interviewee's life lived. This has of course influenced the analysis in certain ways.

However, I think that one of the strengths of qualitative research is that there can be several perspectives on one phenomenon. Actually, it would be interesting to have social workers from different countries and contexts analyse the same interview and compare the results. Such a comparative study could give a broad spectrum of perspectives on social work practice and underlying academic theory in different countries.

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VI Does past life matter? – Social workers' views on biographical approaches¹

Johanna Björkenheim

Abstract

The article discusses the application of biographical approaches in social work practice and aims to identify issues that may need to be taken into account when implementing these approaches. The essays of 16 Finnish social workers, working in psychiatry, addiction treatment, rehabilitation, gerontology, pre-adoption counselling, and vocational education, were analysed regarding the respondents' views on the benefits of biographical approaches, especially biographical interviewing. Qualitative content analysis was used. The results indicate that biographical approaches can create a space for user reflection and social worker listening as well as provide a better understanding of service users' situation. However, concerns regarding limitations of the approach, ethics and necessary professional competencies were raised. The conclusions drawn are that social work practice can benefit from biographical interviewing done with awareness and ethical sensitivity and that 'biographical lenses' as a metaphor for a general attitude can be applied in most practice situations. The paper draws on a wider literature on biographical approaches in the social sciences.

Key words: social work; biographical approach; life story; reflection; listening

Introduction

Although commonly used in social work practice, 'biographical approaches' are seldom mentioned in general social work text books (Behnisch & Kämmerer-Rütten, 2009). However, interesting discussions about the use of biographical methods in professional practice are going on in other forums of social science.

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Why is it important to discuss biographical approaches in social work practice? First, whether asking for them or not, social workers are often presented with service users' life stories. How they deal with the stories matters; the approach should be conscious and professional. Second, the present situation of a person/user can be best understood when related to the collected life experiences of that person (Rosenthal, 2003), and the meaning of major events in a person's life cannot be understood without knowing at what life stage they happened and what were the historical, political and social conditions at the time (Jeppsson Grassman, 2001). Third, in social work, when making plans for the future, service users' own interpretation of their life is crucial. The interpretation becomes visible in the story told.

This paper attempts to answer questions raised in my own practice as a social worker in health and rehabilitation some years ago. When working in the inter-professional vocational rehabilitation unit of a university hospital, I had the task of eliciting biographical information from every service user. Since there was no standard protocol for how this was to be done, I worked out my own way, using open narrative interviewing. Even though I had earlier done biographical interviewing for research (Björkenheim, 1992), doing it in the setting of social work practice raised many questions, not least ethical ones. Later, at the University of Helsinki, I was involved in an EU Leonardo project, where a curriculum for biographical counselling¹ was developed. During this project, a pilot course was arranged in Helsinki, which gave me an opportunity to find out what other social workers thought about the biographical approach. Drawing also on the literature, the views of 16 social workers attending the course are presented and discussed in this paper.

My research question is summarized as:

- *How do social work practitioners view the use of biographical approaches?*

Subquestions:

- *What is the 'biographical working tool'?*
- *How can biographical approaches enhance practice?*
- *What are the particular challenges of biographical approaches?*

By 'biographical approach' in professional practice, I understand any approach that includes service users' past and their own understanding of that past. Narrative strategies in social work (Fook, 2002), stressing the life story told, can be considered

biographical approaches too (Miller, 2000). However, in social work, biographical facts per se are often important and so, in biographical approaches for social work, I want to include not only the life story told but also biographical facts and biographical experiences (life history) (Rosenthal, 2004). Generally, 'biographical' and 'narrative' overlap but are not the same: biographies are often presented in a narrative form, but not all narrations are life stories.

Following a literature review and a methodology section, the results of my analysis are presented in three sections and interpreted and discussed in a separate section at the end.

Biography in social work practice

In the literature, the use of biography in professional practice seems to be discussed generally at two levels: On the one hand, there are detailed descriptions of specific biographical approaches and techniques, such as 'life story work' (Ellem & Wilson, 2010), 'biographical counselling' (Betts, Griffiths, Schütze & Straus, 2009; Biography & Social Development Trust [<http://www.biographywork.org>]), 'biographical structuring' (Fischer-Rosenthal, 2000), and 'reminiscence work' (Van Puyenbroeck & Maes, 2006). On the other hand, there are outlines of biography as a general holistic framework for practice, sometimes linked to a profession-theoretical discussion (Behnisch & Kämmerer-Rütten, 2009; Roer & Maurer-Hein, 2004) and using terms such as 'biographical attitude' (Roer, 2009, p. 193) and 'sensitisation for biographical underpinnings' (Betts et al., 2009, p. 7).

As to using biographical techniques in professional practice, it has been suggested that biographical research methods be applied for producing and analysing life stories (Betts et al., 2009; Chamberlayne, Bornat & Apitzsch, 2004; Hanses, 2004; Völter, 2008). One such biographical research method is the biographical narrative interview (Rosenthal, 2004; Schütze, 2009b; Wengraf, 2014), where, first, the interviewees tell their life story freely without interruptions; after the main narration the interviewer asks narrative questions; and at the end descriptive and argumentative questions can be asked (Schütze, 2009b).

Because a professional practice setting clearly differs from a research setting, social work researchers argue that certain considerations are needed when applying

biographical methods in social work practice (Barker, 2009; Behnisch & Kämmerer-Rütten, 2009; Björkenheim, 2014; Völter, 2008).

‘Life story work’ as part of social work intervention has been described as reconstructing the individual’s life story with the aim of helping the person to make sense of major life events and identify needed changes; life stories can be constructed in interviews, as life storybooks, or by other communicative tools (Ellem & Wilson, 2010). Life story work is found useful, for example, with children in care, adopted children, people with learning difficulties and older people in residential care (Bornat & Walmsley, 2004). ‘Biographical work’, on the other hand, is the reflective work individuals do in order to come to terms with their life; the ‘work’ can be almost subliminal, but in situations of biographical crisis it often becomes more conscious; autobiographical storytelling has been found to entail biographical work in the narrator (Betts et al., 2009, pp. 26-31).

As to the literature on biography as a wider theoretical framework for professional practice, the main gain seems to be the provision of a holistic view of the individual (the service user) in the social world, a sociological alternative to the individual-psychological and the economic orientations (Roer, 2009). Biography is even suggested as a new paradigm for developing social work professionalism (Roer & Maurer-Hein, 2004). Roer (2009) presents an outline for ‘biography work’ as a type of reconstructive social work where the service user is defined as a ‘biographical actor’ (Heinz, 2009, p. 478) who is able to (re)construct not only his/her own biography and identity but also his/her own world. In Roer’s (2009) outline, the task of the social worker is to reconcile the perspectives of subject and structure through an intervention that the service user sees as fitting into his/her life plan. The users are given an active role in planning their future, where biography is seen as a resource, not a problem. This work requires a ‘biographical attitude’ (Roer, 2009, p. 193), the central aspect of which is respect for the user’s autonomy.

Part of the criticism made of ‘biographically informed practice’ (Apitzsch, Bornat & Chamberlayne, 2004, p. 7) pertains to the effectiveness (Barker, 2009) and effects (Rickard, 2004) of biographical methods. Concerns have been raised too about biographical approaches laying too much emphasis on people’s own responsibility and disregarding the risk of social problems being reduced to the individual-biographical level; on the other hand, the approaches may support values of egocentrism and individual freedom at the expense of solidarity and social rights (Behnisch

& Kämmerer-Rütten, 2009). There is also a risk of overinterpreting fragmental biographical data in a deterministic way (Reichmann, 2010). Biographical approaches may contain social expectations of normalisation of the individual (Benisch & Kämmerer-Rütten, 2009; Kyllönen, 2004).

An empirical study

A pilot course, connected to the EU Leonardo project INVITE¹, was conducted at the University of Helsinki in 2005-2006 and was targeted at Master-level students and practising social workers. Information about the course was sent out primarily to social work practitioners working in or close to the fields of health and rehabilitation. The course aimed at raising a general interest in biographical approaches and consisted of lectures given mainly by biographical researchers, reading of texts produced in the project, group discussions, and home work including a final essay. The main biographical 'working tools' presented at the course were the biographical narrative interview (Rosenthal, 2004; Schütze, 2009b) and the 'biographical lenses'. The concept of 'biographical lenses' was introduced by one of the course lecturers (Kalland, 2006) as a metaphor for a general attitude of affirmation, which opens up for biographical reflections and supports users' biographical work. The course participants were encouraged to attempt biographical interviewing and 'biographical lenses' in their own professional practice.

Research data consist of the final essays of 16 respondents out of a total of 25 course participants. All the respondents gave permission for their essays to be used for research purposes. In the instructions for the final essay, participants were asked to reflect on the benefits of the course and/or assess whether and how it possibly had or would change their way of working. Sixteen (A-P) essays dealt more specifically with the application of biographical approaches in practice. The number of pages analysed was 103 (3-17 per person). Some of the respondents later commented on the subject by e-mail or at a follow-up seminar six months later, and these comments are included in the research data. All the respondents had worked as social work professionals for at least 4 years. During the course five of them worked in psychiatry (A-E), four in addiction treatment (F-I), three in rehabilitation (J-L), one in long-term residential care for persons with brain injury (M), one with the elderly (N), one in pre-adoption counselling (O), and one in a vocational college (P). All were female and over 31 years of age.

Research data² were analysed using qualitative content analysis with an abductive approach, where theory and data interplay (e.g. Timmermans & Tavory, 2012). Based on the literature and my own work experience, I had some understanding about the benefits and challenges of biographical approaches in social work but wanted also to stay open to new ideas emerging from data. Some of the categories and themes I initially looked for in the data were: positive and negative/doubtful statements about biographical approaches, type of users found suitable or not suitable for the approach and descriptions of different 'biographical interventions' (the working tool). New categories, emerging from the data, were the documentation of life stories, ethical considerations, and the prerequisites for biographically informed social work practice. Identifying positive and doubtful statements about the approach was not too difficult, and the respondents' elaborations on their statements created new categories. However, it was not possible, in these limited data, to identify user-specific biographical interventions. The results were grouped around a few main emerging themes and are presented in three sections: life stories and biographical lenses as working tools, the benefits of biographical approaches, and the challenges of biographical approaches.

Life stories and biographical lenses as working tools

As mentioned before, the main biographical 'working tools' discussed at the pilot course were the biographical narrative interview and the 'biographical lenses'. Other tools mentioned in the essays were, for example, photos, calendars, memory objects, letters, diaries, pictures, life lines, network maps, time circles. In this section, the respondents' descriptions of biographical approaches as working tool are presented.

Exactly how the respondents performed their assignment of biographical interviewing (BI) cannot be concluded from data, but it is clear that the open biographical narrative interview method as used in research had to be modified for practice. Social work interviewing usually requires a more structured approach with more dialogue.

When you make a work capacity assessment, you usually go through the life history, so I thought BI would be good for this purpose. I tried to let the person talk as much as possible without me interrupting. Almost at once, I noticed that it did not work very well, because I have to make up a document based on the interview and it has to be logic and communicate certain facts. (B, psychiatry)

Not just oral, but also written, life stories were considered productive. For example, service users could be asked to write down their life story before their first meeting with the social worker or process their life story in writing between counselling sessions. The life stories could be written jointly or separately.

Two main purposes for using BI were identified: to elicit biographical information and to be used as a tool for change. The two were seen to go together: eliciting biographical information through BI entails biographical work in the interviewee. The respondents acknowledged that life stories are not exact representations of real events (cf. Schütze, 2009a).

A social worker must understand that a story may change over time and that this does not necessarily mean that the client has lied. Substance abusers may quite often deny their abuse in the beginning of the treatment. When they gain more insight in their own problem, their story will most probably change. (H, addiction treatment)

Different ways of using life stories were suggested. A story could be analysed to make an assessment as a basis for planning intervention, it could be analysed as a joint activity with focus on, for example, the turning points of life or on choices and situations in the past influencing the present, or the focus could be on the storytelling itself. Users, needing more support in telling their story, could be helped by questions. A life story perspective was found useful in making plans for the future too.

I could ask the patient how she wanted the story to continue, what else she wanted to do in life. (A, psychiatry)

Timing was seen as crucial. BI could be used in the initial assessment phase.

We could ask more open-ended questions in the first interview. For instance, we could ask the clients to tell us about themselves or ask them what they think we should know about them. The social worker could be more of a listener and ask questions only if necessary. At present, we base the first interview on specific questions about the client's substance abuse, but these could well be answered later in the treatment. (H, addiction treatment)

A respondent in psychiatry described how she successfully introduced BI in her long-term counselling relationship with a woman who had made several suicide attempts and spoke very little.

Life stories were seen to work well with service users in all the fields represented in data as well as with users of different age. The gerontology social worker found biographical approaches useful both in the assessment phase and in the intervention phase. The school social work respondent found both oral and written life stories useful but emphasized that young persons' life stories should not be used for eliciting information (cf. Völter, 2008); they should merely serve as a means for identity construction. For instance, students who are uncertain about their vocational choice or feel 'lost' could benefit from a life story approach.

During the first weeks, all students receive a form with questions about studying at our school. I added an open question, a generating question, asking them to tell me about their life and what had been important and meaningful to them. I asked them to write down what they thought about the future. (P, vocational school)

However, the respondents had doubts too about the effectiveness of BI. Users would not always talk about the specific issues that should have been the focus of the interview (cf. Benisch & Kämmerer-Rütten, 2009).

Isn't there a risk that the biographical approach will allow the client NEVER to get into (talking about) and be confronted with his drinking problem? (F, addiction treatment)

And the respondents realised that BI is not a 'universal' method fit for all situations.

The biographical method must not be an end in itself. The social worker must assess and decide when the method is appropriate. (F, addiction treatment)

BI was not productive with all service users. Some users were not talkative, had mental problems or were suicidal. Persons with depression were seen as possibly gaining from BI, but they could be too depressed to concentrate, recall only negative events, or in general have problems with memory. Persons in acute crisis seldom had the strength to work on their biography (cf. Rosenthal, 2003).

Generally, BI was found to be useful particularly in assessments of users' social situation or work capacity, in diagnostic examinations (neurology, psychiatry), in long-term counselling, in care and rehabilitation planning, and in rehabilitation counselling.

Besides individual work, autobiographical storytelling was often productive in peer groups, especially in rehabilitation and addiction treatment.

'Biographical lenses', implying verbal or nonverbal validation of a user's biography as lived in a socio-historical context, even when the life history is not discussed or known, were found to be a useful working tool in most situations, particularly in shorter counselling sessions, in rehabilitation groups and in social work assessments where BI was not possible or necessary.

The 'biographical working tool' seemed to have an empowering effect not only on the service users but also on the workers (respondents) (cf. Roer. 2009). One respondent, who had recently started work in an inter-professional setting of long-term residential care for persons with brain injury, felt that the biographical approach strengthened her professional identity. Another respondent, working in rehabilitation, found that her new, 'biographical lenses' had become indispensable. She could 'hardly see without them' any longer and believed that her clients could sense whether she was wearing them or not.

Biographical approaches enhancing social work practice

The benefits of biographical approaches, mentioned by the respondents, divided into three main themes: service users' reflection, social workers' listening and the workers' improved understanding of users' problem situation.

A space for user reflection

Most respondents found that life-story telling enhanced service users' reflection and identity work.

With biographical tools it is possible to ask questions like: Who am I? Where do I go from here? These questions enable clients to study their own identity more closely. (K, rehabilitation)

Users who were capable of reflecting were seen to manage and adapt better, for instance, to sudden illness. The reflecting process elicited by autobiographical storytelling served as an empowering experience.

Reflection helped the user to rediscover resources she had lost and to see positive things in her life too. (L, rehabilitation)

In pre-adoption counselling, the aim of biographical interviewing (BI) was seen as not just to collect information about the presumptive parents but also to help the couple to do necessary identity work.

My task is to start a reflective process in the applicants and make them reflect on their lives, motives and fitness to become adoptive parents. It is about helping the clients to find a new role as adoptive parents through a reflective process. (O, pre-adoption counselling)

A rehabilitation respondent formulated the following definition of biographically informed social work practice:

Social workers can support the biographical work of their clients by suggesting to them different ways of telling their life story, by listening and by offering them opportunities for systematic reflection and thus helping them to construct a means for dealing with their past and finding resources for the future. Interventions and interpretations are limited compared to those used in psychotherapy. Instead, the work is based on social work methods. (J, rehabilitation)

Supporting users' biographical work was considered an essential task for social work practice.

A space for social worker listening

The respondents strongly emphasized having become more aware of the importance of listening to the service users.

I think the course has made me a better listener. The biographical method gives the client space to reflect, time for a genuine meeting. (L, rehabilitation)

Some had become conscious of their tendency to interrupt users' storytelling and realised that they ought to make a greater effort to just listen and be present.

I have noticed that it is difficult for me to just let the client talk; I often want to take a more active hold. Here I have some learning to do. (B, psychiatry)

Active listening was also seen as a means of support to users who are lonely or have nobody around to listen to their story. A biographical (narrative) disruption could be bridged by letting the person tell his/her story. If given time, service users were often seen to find the means to tackle their own difficulties.

It was comforting to know that it is enough to put on my 'biographical lenses' and let the client produce freely and tell me about his life. I do not have to interpret everything. (F, addiction treatment)

The gerontology social worker pointed out that elderly users need much time to tell their story and reflect on it; their life is longer and their functioning often slower than that of younger persons.

Enhancing deeper understanding

Several respondents mentioned the importance of a 'holistic' perspective in understanding users' problem situation.

Even though, during a short rehabilitation period, we are not primarily interested in the complete life story of the client, we are still interested in getting a whole picture of the situation. (H, addiction treatment)

And they found a biographical approach promoting that perspective.

Just as vocational rehabilitation stresses holism, I think that the concept of 'biographical lenses' recognizes the fact that humans have a past, a present and a future. (L, rehabilitation)

The micro-macro relationship was found interesting in understanding how socio-historical processes and life conditions are intertwined with service users' own aspirations and efforts to gain and maintain autonomy (cf. Betts et al., 2009). The respondents could see that users with similar problems do not necessarily have similar life histories and vice versa.

The use of biographical knowledge is a way out of thinking in paths of cause and effect, where childhood events are seen to determine future events. (E, psychiatry)

Moreover, BI often elicited more relevant information about users' situation than structured questioning, because important questions were answered which might never have been posed by the worker.

Challenges of biographical approaches

The main challenges of biographical approaches, mentioned by the respondents, had to do with the user/worker relationship, ethical considerations and the prerequisites for using these approaches.

The user/worker relationship

It was stressed that successful biographical interviewing (BI) requires a trusting relationship between interviewer and interviewee (cf. Riemann, 2003). And building trust was regarded as challenging and time-demanding.

I see certain disadvantages in using the biographical method in short (2-week) addiction rehabilitation, because it may be difficult to build sufficient trust in such a short time. For many clients though, long-range rehabilitation plans are made, and with that group BI may be more appropriate. (H, addiction treatment)

The respondents liked the idea that the biographical approach defines their role as not being the expert, who interprets users' biographies, but as being a 'co-traveller' with whom users can discuss their problem situation. This means that social workers can trust that ultimately the 'keys to change are always in the hands of the persons themselves' (L, rehabilitation). The workers' optimism about service users' own resources for change was reflected in the users.

Now I have seen that, by finding 'explanations', the client feels that it is, after all, possible to examine the drinking problem and deal with its consequences. (G, addiction treatment)

Should the professional doing the BI also be the one to follow up on the case? There were divergent views on this. Some respondents thought the same worker should follow up after subjecting a user to such strenuous interviewing. Others thought that, for instance, another member of the inter-professional team could well take over the client after BI. These opposite views may relate to differences in the working context and seem to indicate that BI can be used both in long-term counselling and in short-term/diagnostic work.

Consent, ethics and documentation

It was seen as necessary that users explicitly consent to BI or are at least informed in advance about the purpose of it and about how their life story will be used later.

I now give the patient more detailed information about what we are going to do and why. I tell him that the whole team has access to the story, so he knows that the story does not stay between the two of us. (C, psychiatry)

The respondents also wanted to let the users set the boundaries for their story.

In most cases the patient is capable of self-regulation and does not tell you more than he is able to handle. But it is important that you know the patient and know when not to ask further questions, even if you would like to. (A, psychiatry)

The school social worker raised ethical concerns about letting students recollect traumatic life events, taking that the school should provide a positive environment. She also questioned whether a school social worker is capable of dealing with all the memories that may arise during BI, and whether this benefits the student, but saw 'biographical lenses' as generally helpful. This respondent recommended 'a sufficient amount of biographical thinking in combination with solution-focused and strengths-based perspectives'.

The question of what and how much of the abundant information, retrieved through BI, should be recorded in agency files was seen as difficult. At least, users should know what is recorded about them.

Before I put the story I have written into the file, I go through it

with the patient. We may revise it, correct misconceptions, perhaps take out something that they do not want there. (C, psychiatry)

Prerequisites

The individual prerequisites for doing biographically informed social work were thought to consist of formal knowledge, competencies and personal qualities.

As formal knowledge a social work education, some knowledge of biographically informed professional practice, and good knowledge of the social work field in question were judged sufficient.

Necessary competencies mentioned were the capacity to view the work as a process, to create trusting relationships, to take time and patience to listen to users without judging and to allow enough space for storytelling and reflection. Biographically informed social work practice presupposes professional competence and ethical awareness.

I think that to open up knots of the past you need to have professional competence and time to go into the client's situation and into emotions possibly evoked by the memories. (G, addiction treatment)

Biographically informed social workers do not fear stories about traumatic life events or strong emotions of sorrow, despair and anger; they know how to respond and give support without being drawn into users' stories. They also understand their own limits and know when to make necessary referrals to therapists/psychologists. Differences in age and life experience between interviewer and interviewee were not seen as impediments to building trusting relationships.

Finally, on a personal level, biographically informed social workers understand their own values and prejudices and work on these through self-reflection. Other necessary qualities mentioned were natural curiosity, interest in people and readiness to deal with their own biography.

Some of the prerequisites for using biographical approaches were seen to depend on external factors, such as the employing agency. The time allocated for meetings with service users may not allow sufficiently for dealing with their life stories.

Five persons regularly write down their story but I have no time to work with the texts. (I, addiction treatment)

There should be enough time later to continue dealing with difficult memories that may have come up. (A, psychiatry)

Introducing biographical methods at a workplace was thought to require a joint decision, because all colleagues might not be familiar with them. Particularly in inter-professional teams, where different team members work with the same user, it was judged necessary that the whole team agrees on the use of biographical methods and decides on the division of labour. Continuous supervision was considered necessary in working with BI.

Discussion

According to the empirical data collected from 16 Finnish social workers, biographically informed social work practice creates a space where service users can reflect and do biographical work and social workers can better listen to what users have to say; at best, the approach enhances a holistic understanding of users' situation, strengthens the relationship between user and worker and empowers them both (cf. Roer 2009). Further, the findings indicate that the approach can be used with different user groups and with users of different age (cf. Behnisch & Kämmerer-Rütten, 2009), at least in the fields of social work represented in the study, which were psychiatry, addiction treatment, rehabilitation, gerontology, pre-adoption counselling and vocational education. However, life story work raises ethical considerations pertaining to questions of confidentiality, informed consent and professional competency.

Generally, the respondents seemed to perceive biographical approaches as providing a holistic working tool, which also conforms well with social work goals and values. By supporting users' reflection and identity work and helping them to find their own strengths and resources in solving their problems, the tool promotes change. Even when used merely to elicit biographical information, biographical interviewing (BI) constitutes an intervention (Rosenthal, 2003). Interpreting life stories in social work is ideally best done primarily by the users themselves (cf. Bornat & Walmsley, 2004). Even so, careful assessment of when, why, with whom and how BI can be used appears essential, as does transparency about aim and procedures at all stages. Service

users with little capacity for storytelling and reflection can be helped by the use of 'biographical lenses'.

An interesting result of the study is the effect biographical approaches seem to have on social workers' view of their own professional role. The generally positive views of the approach may stem partly from dissatisfaction with the more common problem- and action-oriented way of working. Social workers would probably more often like to see their role as one of supporting users' process of change, their biographical work. However, biographical approaches may appear more demanding than task-oriented ones. The significance given by the respondents to competencies and personal qualities in using biographical approaches fits well with the observation made by Roer and Maurer-Hein (2004) that, generally, social workers with a longer work experience are more interested in these approaches than less experienced workers, who often want clearer rules for their work.

A significant prerequisite for a biographical approach is building a trusting relationship between user and worker (Riemann, 2003). This requires good listening skills. Even though social workers supposedly identify themselves as good listeners, this is not always the case (Wilson et al., 2011, p. 301). In social work, listening is challenging, because the stories told often express deep suffering, are difficult to articulate and may evoke feelings of helplessness in the listener, but according to Hydén (2008), narrative competence, understanding storytelling as interaction, can be learned. The respondents seemed surprised that something as apparently simple and obvious as listening to service users' life stories can be considered a 'working tool'. Even though, evidently, listening can be very active and intense and users need time for reflection, social workers do not seem to be quite certain if listening to users' stories can be considered real 'work' at all.

A crucial question for the respondents seemed to be how to decide what information produced in BI should be documented in the files. After all, in an institutional context, the documentation of the meetings with service users is an essential part of the work. In a constructivist perspective, language is important in defining and constructing a person, and so what is written in a case file is not insignificant (Milner & O'Byrne, 2002, pp. 183-185). These mini-biographies start living their own life (Bernler & Bjerkmann, 1990) and may affect how users are met later on. Even though, in theory, users can participate in the documentation (Mann, 2001), this is probably seldom the case. Users' own documents, letters etc. may be

included in the files, but users seldom have much say about what is recorded about them by the personnel.

One of the prerequisites for BI, listed by the respondents, had to do with the employing agency. Will employers allow enough time for the use of biographical methods, which, in a short perspective, may not seem very cost-effective (cf. Barker, 2009)? Roer (2009) is rather pessimistic about this. On the other hand, it would seem that the use of 'biographical lenses', viewing the user as a 'biographical actor', does not necessarily require any more time than the use of other types of 'lenses' that social workers wear, be they aware of them or not.

In discussing biographical approaches, it seems necessary to distinguish between biographical approaches as a working tool, on the one hand, and biographical approaches as a 'paradigm', on the other hand, that is between biographical methods/techniques and 'biographical lenses'. Specific techniques can be used or not used, depending on the context, but the 'biographical lenses' as a paradigm would be applicable in most situations. The concept of 'biographical lenses' seems to resemble Roer's (2009) concept of 'biographical attitude'.

Conclusions

Even though the empirical data were collected in Finland, I believe the results do not differ much from social work practice in other Western countries. Some differences may be caused by the fact that several of the respondents had or were studying for a Master's degree and that all of them were interested in developing their professional skills in this particular area.

Based on the study, it seems reasonable to conclude that social work practice can benefit from biographical methods, particularly biographical interviewing, under certain conditions. However, critics point out that not enough is known about the strengths and weaknesses of biographical methods in clinical work (Rickard, 2004) and that more social work research on profession-theoretical and action-ethical issues is needed (Benisch & Kämmerer-Rütten, 2009). On the other hand, it seems that 'biographical lenses' as a metaphor for a general attitude would be applicable in most practice situations. Actually, the implications of biography as a general paradigm for social work might be worth further exploration.

The 'biographical approach' names what many social workers already see as a normal ingredient in their daily practice. By naming the approach, listening to and working with service users' life stories and life histories becomes a social work 'method', which can be studied, systematically developed and critically reflected upon.

Notes

¹ The project EU Leonardo INVITE 2003-2006 developed a curriculum for teaching 'biographical counselling' to professionals working in vocational rehabilitation (European Studies on Inequalities and Social Cohesion 1-2/2008 and 3-4/2008). The participating universities were those of Magdeburg in Germany, Helsinki in Finland, Wales/Bangor in UK and Łodz in Poland. Practice institutions in these countries and in Austria and Italy participated as well.

² The essays were written in Finnish or Swedish (the course was bilingual). The quotations have been translated into English and have been written out to be as readable as possible, since content, not form, is analysed.

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