

MAGICAL REALISM:
A NEW TOOL FOR EMPATHETIC NURSING

by

Stefanie Ray

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Thesis Supervisor:

Barbara Covington

Second Reader:

Amanda North

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DEDICATION

To the nurses fighting to end the coronavirus pandemic.

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ABSTRACT

This work explores the potential for nurses to improve their patient care by applying principles of narrative medicine to the close reading of magical realism fiction. Narrative medicine is a discipline that recognizes the similarities between fictional narratives and the clinical physician-patient encounter. Today, the discipline of narrative medicine focuses entirely on physicians, with little to no exploration of its application to nursing. Nurses should have access to programs training in narrativity because their role in patient care requires almost constant emotional and physical contact with patients. Magical realism is a subgenre of fictional literature that weaves supernatural elements into a realistic setting in order to create liminal spaces that are well-suited to challenging established modes of thought. Because of the specialized techniques employed in this genre, it has a powerful potential to foster empathy in readers. In this thesis, literature reviews are conducted for the topics of narrative medicine and magical realism, investigating the possibility of utilizing them to increase empathy in nurse-patient encounters. To make the results of the research accessible, a step-by-step guide is included for nurses with no prior knowledge of narrative or literary theory to educate themselves in close reading with the goal of fostering empathetic growth. This thesis opens the door to research for the discipline of narrative nursing.

I. INTRODUCTION

Patients are storytellers; illness is their story. It is the responsibility of every healthcare provider to listen to, empathize with, and understand the patient experience in order to build trust and provide better care. With patients as tellers and caregivers as listeners, a narrative emerges in every clinical encounter.

Using this connection, scholars have developed a new discipline that argues for the potential of the narrative skills used in close reading of fiction literature to re-center medical care around the patient. Narrative medicine practices have been shown to improve physicians' interpersonal skills, individualize their treatment, and give patients agency in their care. While the principles of narrative medicine are sound, important applications have been left out of the conversation. The discipline mainly focuses on the physician's relationship with the patient, but there is a much more significant need for the subjectification of nursing treatment because of the constant physical and emotional contact in which nurses necessarily engage with patients. Additionally, specific genres of literature are especially well-suited to narrative training for the clinical environment, one of them being magical realism.

Magical realist texts weave supernatural phenomena into realistic settings. This merging of worlds creates a liminal space where characters and readers alike are permitted to question the fundamental truths of our world. The emphasis on liminal space is a key element of narrative medicine theory, yet magical realism has not been seriously considered as a specific pursuit of the discipline.

To synthesize these concepts and fill the gaps, I have compiled research exploring how nurses can improve their empathetic patient care by reading magical realism

literature. The first section of this thesis consists of a literature review of narrative medicine which establishes a foundation of knowledge of clinical narrativity. Narrative nursing is proposed as an independent discipline rather than a smaller branch of narrative medicine.

The next section is a literature review of magical realism that exposes its powerful capacity for healing via postcolonial discourse and psychotherapy. Following this is a chapter defining empathy in the context of nursing. Once the three concepts of narrative medicine, magical realism, and empathy are established, a discussion chapter synthesizes them to argue that nurses can improve their patient care in this way. To supplement this argument, I have included a step-by-step guide that instructs nurses how to apply these theories to the actual close reading of magical realism texts and practice of narrative nursing techniques.

II. LITERATURE REVIEW OF NARRATIVE MEDICINE

Introduction

Narrative medicine is a relatively new interdisciplinary field that teaches physicians to use literary techniques including close reading and reflective writing to develop empathetic skills. The goal of the discipline is to address the problems of detached patient-doctor relationships that persist in modern clinics by diving deeply into the mechanisms of fictional narratives and applying them to the narrative environment of the exam room. Due to the ambiguity of the term *narrative*, scholars disagree on the effectiveness of this work and how it ought to be conducted. This literature review will explain some prominent views in the discipline and examine the controversies. Following that synthesis, the gaps in narrative medicine will be identified and addressed.

Overview of Narrative Medicine

Dr. Rita Charon, a physician and professor at Columbia University, coined the term *narrative medicine* and is considered the founder of the discipline. She defines it as medicine practiced with the ability to recognize and interact with the stories of others (Charon, "Narrative Medicine", 1897). This ability is commonly referred to as *narrative competence* and it depends on the recognition that doctor-patient interactions are inherently narrative; they consist of a teller (the patient) and a listener (the doctor). It is the physician's responsibility to both create a space for the patient to tell her story and to pay close attention to that story in the same way that a reader pays close attention to a fictional text. Narrative competence is the skill required to navigate interactions in this way. Practices like close reading can enhance narrative competence so that patients are both heard and empowered, and physicians are better equipped to treat them.

Rita Charon also spearheaded the compilation of a book entitled *The Principles and Practice of Narrative Medicine* in which she and her colleagues describe in detail the innerworkings and implications of a narrative-based patient encounter. This book recognizes four main areas of clinical care in which narrative medicine plays a part: (1) intersubjectivity, (2) dualism, (3) transitional space, and (4) bioethics (Charon et al. *Principles*, 3).

Charon's Four Areas of Clinical Care

Intersubjectivity is term that encapsulates the bidirectional relationship between a doctor and a patient (Charon et al. *Principles*, 34). Both parties are equally involved in the active construction of the patient's story: the physician first asks open questions to gather information about the situation, then the patient verbalizes his experiences in a way that makes sense to him, and finally, the physician listens to understand the verbal and nonverbal elements of the patient's self-telling. This is where skills like close reading come into play. If a physician is accustomed to paying close attention to a fictional text, he can apply the same skills to close listening to a patient's narrative (Charon et al. *Principles*, 16). Because literary fiction is rich in dialogic exchanges and descriptions of relationships, by reading these actively, physicians can become sensitized to the nuances and complexities of conversations. Then, they can apply these techniques to the patient encounter. The physician begins to perceive the patient as a whole story, a character in this narrative, with real doubts, fears, and hopes. The conversation becomes more active for both parties than a simple list of symptoms and clicking of boxes on a screen; it establishes trust and prevents the physician from treating the patient as solely a body.

Dualism is a term that represents the human state of being both physical body and metaphysical mind (Charon et al. *Principles*, 106). This is a critical issue in the healthcare field, where the primary goal is often bodily health and, as a result, caregivers often objectify their patients as bodies. This neglect of the mind can lead to the desensitization of physicians and the alienation of patients. Physicians who read literature closely have an enhanced ability to mentally unite patients' bodies with their abstract identities because they have engaged with the dualistic nature of fictional characters. In addition, if physicians practice reflective writing techniques taught in narrative medicine, they have an opportunity to routinely check in on their treatment of patients as people rather than bodies (Charon et al. *Principles*, 215).

Transitional space, also called *thirdspace*, refers to the "in-between" state of a patient's self-perception during a time of illness (Charon et al. *Principles*, 151). People tend to consider their healthy selves their "real" selves. Therefore, any shift from health is a shift towards the unreal, and this adjustment causes conflict, tension, and fear within the patient (Charon et al. *Principles*, 277). The transitional space seen in disease also exists in literary fiction; the author takes real human experiences and explores them in an imaginary narrative space. This characteristic is especially prevalent in magical realism literature, which has not been utilized in the discipline of narrative medicine but will be discussed in a later section of this thesis. A physician trained to recognize the thirdspace in fiction can better navigate it in a patient's narrative to help him accept that he can be both real and sick. This acceptance of the thirdspace can settle a patient's internal conflict and restore his sense of control over his situation.

Bioethics is a discipline that encourages moral treatment of every patient in every situation. The healthcare field requires the ability to navigate difficult moral decisions, and narrative medicine explicitly assists clinicians in this pursuit. Charon states, “one cannot read a novel or poem or essay without being ethically engaged” in the experience of the characters (*Principles*, 122). Reading requires constant judgement of situations and their moral implications, even if this judgement is subconscious. By acknowledging this, physicians can expose their own biases and assumptions and practice making ethical judgements while reading. When a dilemma occurs in the clinical environment, the physician will be better equipped to handle it.

Additionally, narrative medicine promotes social justice by exposing healthcare workers to the stories of people who are different from them (Charon et al. *Principles*, 172). It is easier to be empathetic towards a patient of a different culture when the caregiver has read the narrative of a character in a similar situation. This empathy, along with the practice of bidirectional conversation, modifies the power structure of physician over patient. This dissolution of hierarchy allows the physician to see and treat patients as equals and gives patients more agency in their treatment (Charon et al. *Principles*, 173).

The collaboration of eight narrative medicine scholars in *The Principles and Practice of Narrative Medicine* gives the discipline a clearer shape and purpose. The main idea that Charon and her colleagues leave us with is that narrative skills are necessary to the intentional and just treatment of patients. Additionally, these skills can be continuously enhanced by the practices of close reading and reflective writing.

The Need for Subjectivity

If clinical practices are inherently narrative, then when they are approached with a purely objective perspective, they fail the patient (Greenhalgh 323). Most scientific fields consist of clear-cut, repeatable procedures—chemical reactions and physics equations are standardized so that they can be approached the same way in every case. The danger of considering healthcare as a science is that by approaching it with this objectivity and repeatability, the caregiver must assume that patients are all the same. However, every patient's body is different. Every patient handles disease differently. Every patient has different responses to treatment. In this respect, medicine is not only a science, but also an art that requires interpretive discernment. Medical practice is a combination of textbook knowledge, specific case features, and the physician's personal experience that allows her to provide the best care for this particular patient (Greenhalgh 325). It is only by acknowledging the unique narrative presented in every clinical encounter that physicians can treat their patients well.

Controversy

A major area of dispute is the definition of the word *narrative*. In literature about narrative medicine, it is rarely defined outright. Some scholars claim that the ambiguity of the term is detrimental to the practice, as its meaning and use vary from study to study. If the term and its characteristics are not clearly defined, it is difficult to establish methods to apply it.

Rita Charon's foundation of narrative practices relies heavily on the development of narrative skills such as close reading and reflective writing. She claims that knowledge of these is the single most important way to return subjectivity to medicine (Charon et

al. *Principles*, 3). Rolf Ahlén criticizes Charon's argument by observing that the skills she promotes require extensive knowledge of literary theory, which is inaccessible to many physicians (Ahlén 8). He also asserts that there is not adequate empirical evidence to support the idea that narrative skills are significantly beneficial to the improvement of patient-centered care (Ahlén 9). Few studies have been conducted around this topic at all, and those that have present obvious bias issues, as most participants already had experience or interest in narrative medicine.

A Reformative Perspective

In his essay, "Narrative Knowledge, Phronesis, and Paradigm-Based Medicine", Ronald Schleifer addresses the shortcomings of narrative medicine and reshapes it into a more practical and accessible discipline. Schleifer clearly defines *narrative* as "verbal acts consisting of *someone telling someone else that something happened*" (71). The definition is inclusive and allows Schleifer to stand on the side of the debate that believes that all experience is narrative.

He takes this further by asserting that all experience also follows a formulaic narrative structure. These are the features of every narrative: (1) a sequence of events, (2) recognizable agents (characters), (3) an end, (4) a teller and a listener, (5) a witness who learns something, and (6) an experience (Schleifer 72). This structure is provisional and dynamic, and the features can take on different shapes depending on the narrative. Close reading of fiction allows the physician to practice identifying these features so that it is easier to see them in the clinical environment.

When the physician can see the patient's story this way, she can fulfill her role as listener and work collaboratively with the patient to construct an ending to the illness

narrative. Schleifer introduces the concept of the chief concern as an example of a way to incorporate narrative medicine into practice. The patient's chief complaint is widely known as the reason for seeking treatment; it answers the question, "what is wrong?" The *chief concern*, on the other hand, is what the patient wants to achieve by the conclusion of her treatment (Schleifer 66). This is not currently a standard element of the History of Present Illness (HPI), or a question that physicians are commonly taught to ask, but it is important. Every patient is different and therefore has a different idea of a desirable outcome for their illness story. This practice recognizes the ending of the clinical narrative and incorporates that knowledge into treatment. Taking the time to address the chief concern strengthens communication between doctor and patient, gives the patient an active role in his own treatment, and personalizes the encounter to avoid objectifying the patient.

Narrative knowledge is the term Schleifer proposes to describe the awareness of the features of narrative and the ability to identify them (72). This is the only narrative skill necessary to practice empathetic patient-based care. It is systematic yet simplified, so it can be easily taught and learned by physicians who are not knowledgeable in literary theory. It is also flexible and can therefore be personalized to individual patient cases.

Empirical Evidence of the Benefits of Narrative Medicine

In a systematic review of 10 scientific studies based on narrative medicine approaches in 2016, the evidence compiled supports the discipline as both a useful patient assessment tool and an instrument for increasing the well-being of patients (Fioretti et al. 7). The review also concludes that the discipline would benefit from more standardized terminology and procedures, and that more empirical research should be

conducted to further justify the practice. Despite the shortcomings, the data in these studies make a compelling argument for the potential benefits of the implementation of narrative medicine programs.

The Mayo Clinic is one stellar example of the impact narrative medicine can have on real-life clinical practice. A study was conducted in 2013 that observed the variety of programs available at the clinic and associated medical school that taught narrativity training to physicians, students, staff members, and even patients. According to their findings, medical students who participated in the programs felt that they had become more empathetic during the training, other staff members felt a deeper connection with their patients, and patients gained a better understanding of their illness experiences and more agency over their treatment (Rian and Hammer 674). These qualitative results support the correlation of narrativity training with more well-rounded, empathetic, and patient-centered care.

Gaps in the Discipline

Now that the benefits of the practice have been demonstrated, it is important to note that narrative medicine is not without its shortcomings. Nearly all research and discussion about narrativity in the healthcare field focuses on only the physician's experience. Programs implemented at hospitals often open admission to other healthcare professionals, but the specific applications of these ideas to fields like nursing have not been adequately explored. Nurses serve a separate role from physicians, and due to the intimate nature of their patient interactions, they may benefit even more than physicians from narrative training.

Some specific genres of literature, including poetry and clinical realism, have been discussed as especially helpful texts to be used in close reading for narrative medicine purposes. However, the genre of magical realism has not been explored for this purpose, despite the clear connections to thirdspace and dissolution of hierarchies.

I see a present need for modern nurses to refocus their care on their patients, to serve them more empathetically, and to make genuine mutual trust a priority in their care. For these purposes, I am proposing research for another new discipline: *narrative nursing*. Narrative nursing is the application of narrative skills to the nurse-patient encounter. *Narrative skills*, in this context, can be defined as the application of Robert Schleifer's model of narrative knowledge—supplemented by an understanding of intersubjectivity, dualism, thirdspace, and bioethics—to the practices of close reading and reflective writing. Because of the powerful qualities of magical realism literature, the guide I propose will utilize that genre for the practice of narrative skills.

III. LITERATURE REVIEW OF MAGICAL REALISM

Introduction

Magical realism is a literary genre characterized by the intertwining of ordinary and supernatural worlds. In this style, natural objects are instilled with unexplained fantastic qualities which participate in the lives of the realistic characters as if they were part of the norm. This literature review examines the evolution of magical realism in order to provide a more grounded understanding. Following that analysis, I will provide my own operational definition of the term and explain how it can be utilized in narrative nursing.

Overview of Magical Realism

Origins

The term *magic realism* was first coined by German art critic Franz Roh in his 1925 essay "Magic Realism: Post-Expressionism". Roh uses the term to describe an emerging painting genre that responded to the overly exaggerated features of Expressionist art by returning to realistic objectivity. This new genre, however, did not revert all the way to Realism; it retained a mystery that "hides and palpitates behind" the objects in the paintings (Roh 15). In other words, the objective artistic representation of ordinary things is instilled with a subjective representation of the artist's perception of them. Magic realist post-Expressionism is a middle-ground that allows reality to be observed at a heightened state, questioned, and transformed in the artwork (Roh 24). Although the name was originally intended for graphic art, literary critics began to apply it to fiction that exhibited the same juxtaposition.

In its early years as a literary genre, the world of magical realism was disoriented. Many critics disagreed about or misinterpreted the definition, confusing it with fantasy or other similar genres (Reeds 176). Magical realism became more distinct throughout the decades, as acclaimed novelists like Gabriel García-Márquez, Toni Morrison, Jorge Luis Borges, and Salman Rushdie pushed to the forefront. There is still debate to this day about whether certain authors and works belong to this category, but for the most part, scholars agree on several characteristics to define magical realism.

The General Consensus: Primary Characteristics

Specific identifiable features paint the clearest picture of what it means for a work to be magical realism. Wendy B. Faris, a prolific scholar of the genre, provides a list of the five primary characteristics of magical realism in her essay, “Scheherazade’s Children: Magical Realism and Postmodern Fiction”. These elements are consistently repeated throughout the discourse in literary academia. We will examine them in turn here.

(1) Magical realism contains extraordinary and inexplicable happenings. The term Faris, along with many of her peers, uses is “irreducible element of magic” (Faris 167). Magic in its simplest form, not explained away as a dream or metaphor. The dead are really resurrected, characters really fly, entire cities are really wiped off of the planet by a great wind. The shocking nature of events in magical realism is also undercut by the characters’ unblinking acceptance of them. The presence of magic does not surprise inhabitants of these worlds, and its role in their lives is never given justification.

(2) “Descriptions detail a strong presence of the phenomenal world” (Faris 169). The works are grounded in reality with abundant imagery alongside realistic plot

themes such as family, poverty, war, and sickness. Nobel prize-winning novelist Toni Morrison is renowned for her descriptions like this one from *Tar Baby*: “Fog came to that place in wisps sometimes, like the hair of maiden aunts. Hair so thin and pale it went unnoticed until masses of it gathered around the house and threw back one's own reflection from the windows” (62). These worlds are not an escape from real life as much as a heightened state of reality.

(3) The reader may feel unsettled, oscillating between “two contradictory understandings of events” (Faris 171). Since the magical elements are never explained, it is typically unclear whether some events are miracles or hallucinations. The exceptional encounter between Simon and the Lord of the Flies in William Golding’s otherwise realistic novel of the same title is a brilliant example of this oscillation. It is left up to the reader to decide whether the conversation really occurs or is a psychological manifestation of the child’s distress. In cases like these, there is rarely a satisfying resolution that gives a definitive answer, and the reader is left to decide for herself what the truth is.

(4) The reader experiences “the closeness or near-merging of two realms, two worlds” (Faris 172). The most popular examples of this characteristic include the worlds of the living and the dead in the form of ghosts/resurrections and the past and the present through memories and unconventional chronology. Both of these types of merging are dynamic motifs in Gabriel García-Márquez's *One Hundred Years of Solitude*, as the narration slips between time periods and ghosts live decades after death.

(5) Magical realism questions the way we think about space, time, and identity. Authors manipulate reality, creating worlds where systems operate differently and giving

the reader permission to challenge systems in his own world (Faris 173). The style raises questions about what determines a person's identity, whether time is truly linear, and what could happen when different worlds merge into a middle ground. This is a unique opportunity for readers to reflect on their lives and address their own need for healing.

These five primary characteristics can be helpful in deciding whether to categorize a work as magical realism. Though the list is not comprehensive, the features presented are rarely disputed as central to the genre.

Space and Variations

A few characteristics of magical realism literature contribute to the ways it is working to change the world. Manipulation of the fictional space and the psychic, mythic, and gothic variations all contribute to the liminality of the style. Liminal space is a tool that predisposes magical realist fiction to transgress boundaries and dissolve hierarchies, opening up opportunities for cultural and individual healing.

Magical realism literature manipulates the textual space in order to intertwine the natural world and the fantastic world. By overlapping these worlds, an in-between space, also called a *liminal space*, is created where the story takes place (Wilson 222). The in-between-ness of the magical realist world heightens the themes which the author wishes to target and expose, and the characters undergo their metamorphosis within the liminal space. Liminality is a new way of thinking that challenges the reader to grow and change alongside the characters. This special treatment of space is a sort of combination of Faris' five primary characteristics, as it merges the extraordinary world with the phenomenal world, creating multiple possible understandings that challenge held beliefs about institutions and identity. Liminal space gives magical realism the power to fuse

irreconcilable worlds “more than other modes” of fiction, which opens the door for the transgression of boundaries, and all the implications that come with that (Thiem 244).

In her essay, “Psychic Realism, Mythic Realism, Grotesque Realism: Variations on Magic Realism in Contemporary Literature in English”, Jeanne Delbeare-Garant identifies three main offshoots which she feels better categorize and define magical realism. The first is *psychic realism*, which she defines as “a physical manifestation of what takes place inside the psyche” (Delbeare-Garant 255). The Simon-Lord of the Flies encounter mentioned earlier is an example of this type of magical realism. The second one she mentions is mythic realism, in which “magic images are borrowed from the physical environment”, warping real spaces to become a liminal space (Delbeare-Garant 253). In these instances, the landscape becomes an active character in the story, impacting the lives of the characters in fantastic ways. The third and final offshoot she identifies is called grotesque realism, a “hyperbolic distortion that creates a sense of strangeness” (Delbeare-Garant 253). This variation is especially prevalent in Salman Rushdie’s acclaimed novel *Midnight’s Children*, which utilizes intense descriptions of bodies to represent the modern history of India.

Magical realism does not have to be an exclusive genre with strict boundaries. These offshoots can be found in novels of other genres, and analyzing texts with these more flexible definitions provides potential for inclusion. This way, classification of a work as magical realism can mean that the text contains magical realist qualities at some point, not necessarily throughout (like *Lord of the Flies*). Magical realist qualities include the five primary characteristics, the use of liminal space, and/or Delbeare-Garant’s three variations.

Practical Applications of Magical Realism

I have claimed that magical realism is changing the world. The main avenue for this, the one recognized by most of literary academia, is the genre's role in postcolonial discourse. Some minor movements have also emerged applying the concepts of magical realist fiction to a psychological therapeutic environment. The characteristics that set the genre apart from others make it especially suited to promoting healing in those who have undergone cultural or personal trauma.

Postcolonialism is noted as a major purpose of the magical realism literature that has arisen from marginalized regions of the world. Up until the birth of magic realism, the attention of academia was centralized in mainstream genres like Romanticism and realism, made of disproportionately European or otherwise Western authors. The stories being told were all from the perspective of these "privileged centers" until magical realism started gaining momentum in Latin America, South and Southeast Asia, and other heavily colonized regions (D'haen 200). This genre was the first not from a mainstream center to be taken seriously, and it shifted the focus away from stories of white colonizers and towards the colonized. Additionally, magical realist authors appropriate the dominantly Western genre of realism, then subvert it by adding their own experiences of the real world as magical elements which dissolve the hierarchies.

Beyond its geographical roots, the content of magical realist fiction tends to address the culture shock of colonization and the pain that results from marginalization in one's own home country. The merging of the worlds of magic and reality mirrors the unsettling merging of cultures as a result of war and imperialism. Real histories of colonization are also often included in the plot, such as the political unrest in Colombia

that frames García Márquez's *One Hundred Years of Solitude*. Stephen Slemon emphasizes the way that magical realism often includes binary oppositions without allowing them to be arranged into a hierarchy within the story; the real and the unreal, life and death, the present and the past all exist on the same plane (410). This juxtaposition of opposites destabilizes existing institutions in the real world. It forces readers to think about the hierarchies built into our institutions and the ways they affect people different from us. It also shows people who have been oppressed by those systems that they are seen, and by entering into the magical realist worlds, provides hope for a future that is different.

Psychotherapist Sonja Bar-Am describes a different use of the genre in her article "Narrative Psychosis, Stories of Magical Realism". Bar-Am argues that by understanding the mechanism of magical realist fiction, with all its paradoxes, counselling psychologists can create a "Magical Realist listening space" in which to receive their clients' self-tellings of psychotic or otherwise neurodiverse experiences (Bar-Am 17). She discusses the discipline of Narrative Therapy, which relates in large part to Narrative Medicine for psychologists, and she describes her own successes in implementing details borrowed from magical realism into client conversations concerning mental illness. This provides a safe space in which descriptions of experiences can be simultaneously impossible and true.

Gaps

While the conversation about giving voice to the oppressed is abundant in academic discourse about magical realism, very little research has been dedicated to the specific link between reading magical realism and developing a higher capacity for

empathy. Maria C. Scott's chapter "Does Reading Fiction Boost Empathy?" provides excellent insight into the studies that have been done linking reading fiction to increasing empathy levels. She concludes that there is significant evidence to support the hypothesis that empathy can be improved by reading fiction literature (Scott 2). Her research, though intriguing, is somewhat broad and calls for deeper, more specific subsequent studies. The same experiment models could be adapted and used for magical realism and compared to other fiction genres in order to measure the differences in reader response and consider the implications of the results.

Sonja Bar-Am's article is as close as I could find to the application of magical realism to the clinical environment. The clinic in this case is dedicated to the healing of the mind, but Bar-Am presents a synthesis of the use of narrative technique in clinical practice and the value of magical realism in patient care. This opens a door directly to using magical realism in applying narrative to other disciplines, which is the gap I am exposing here.

This thesis addresses the gaps by emphasizing the connection between reading magical realism and developing empathetic skills to be applied to nurse-patient encounters. The concept of narrative nursing bridges the space between closely reading the genre and enacting real, practical changes in patient care. Since magical realism has the capacity to dissolve hierarchies, expose the experiences of others, and challenge unjust systems, application to the healthcare field is vital.

IV. THE ROLE OF EMPATHY IN NURSING

Introduction

Empathy is crucially important to nursing practice because of the necessarily intimate nature of caring for patients. It is also the key to connecting the previous two topics discussed—narrative medicine and magical realism—to improving nursing. There is a serious lack of nursing empathy in healthcare systems, which leads to the perpetuation of discrimination against and mistreatment of patients. One way to better serve patients is to implement empathy training programs for nurses, which have shown to be effective in several studies. This chapter will go into depth about the definition of empathy, its place in the work of a nurse, the need for improvement, and the precedent for studying the effectiveness of empathy training for nurses. In discussing all of these things, I will set the stage for a new, accessible process individual nurses can use to improve their care.

Overview of Empathy

Empathy, as it will be used in this work, is defined as the capacity to understand another person's situation, perspective, and emotions, and to communicate that understanding to the other. There has been much debate, especially in the world of healthcare, as to the classification of empathy as a skill, a personality trait, a state of being, an action, etc. To address this ambiguity, I will now describe the three widely recognized types of empathy: emotional, cognitive, and behavioral (Moudatsu et al.). Each of these three types constitutes a stage in empathetic practice.

Emotional empathy is the initial response a caregiver has when a patient experiences or expresses an emotion. This consists of two sub-stages: the identification of

a patient's feeling and the altruistic motivation or desire to understand it. The second substage is sometimes referred to as *moral empathy*. Emotional empathy is the stage over which we have the least control. Some providers may have a strong natural intuition which allows them to immediately recognize, identify, and share the feelings of their patients, while others may not even think to notice a patient's emotional state. Despite one's natural affinity for emotional empathy (or lack thereof), empathy training can focus on encouraging healthcare professionals to observe and ask about the patient's experiences during treatment and teaching them how to accurately identify the expression of certain emotions. Any kind of empathy training will raise one's awareness of the difference between his perspective and the patient's perspective, which should lead to more attentive care.

Cognitive empathy involves the intentional suspension of one's own perspective in order to gain insight into the patient's perspective. This stage involves critical thinking, close listening to patient accounts, and imaginative exercises in an attempt to think and feel like another person. Because of the conscious effort that must be made to do this, it is the stage most commonly addressed by empathy training. Caregivers who refuse to see situations from another point of view may provide care that they think is best when the patient disagrees. This stage is vital to centering care around the needs of the patient.

Behavioral empathy is the final stage of this practice, and it can come in many forms. It may involve repeating a patient's concern or comment back to him in other words, which both affirms that you understood the issue and also shows the patient that you have paid attention and that you care, which builds trust. If a provider fully understands what the patient is saying, she will be more accurate in reporting symptoms,

in addressing issues, and providing quality treatment. Behavioral empathy involves multidimensional provider-patient communication, giving patients an active role in their own care.

Empathy in Nursing

The patient experience is uncomfortable. It usually involves pain, crisis, and a major shift away from normal life. Besides the presence of disease, disorder, and injury, patients are also subjected to a necessarily intimate encounter with strangers in which they may feel vulnerable and exposed. Awareness of these experiences is vital to treating patients as people rather than as bodies. Among healthcare professionals, nurses have the biggest responsibility to utilize empathy in their patient care.

Nurses come into direct physical and verbal contact with patients more than any other HCP. They are often the first faces to greet patients and listen to the self-telling of their illness. Many conduct the History and Physical examination, in which they ask patients personal questions about their identity, lifestyle, and general health and conduct a physical assessment involving direct touch. These initial duties require close, attentive listening and the conscious effort to make the patient feel comfortable. Trust built in this first encounter can go a long way in establishing rapport, which will make the patient feel more comfortable sharing personal details and allowing themselves to be touched in the future.

If the patient is admitted, nurses also perform basic yet intrusive procedures such as insertion of IVs and catheters, drawing blood, taking vital signs, intubation, range of motion assistance, and drug administration. Patients who cannot complete activities of

daily living such as dressing, feeding, toileting, oral hygiene, and bathing on their own must also rely nurses for assistance.

In addition, nurses have a responsibility to check on patients countless times during their stay, which means they are the workers patients see the most. If a patient's nurse has developed rapport properly and a trusting bond has been established, the patient is more likely to feel comfortable expressing their feelings about certain elements of their care to the nurse. Nurses can better evaluate changes in emotional, mental, and physical health if they have an empathetic connection with the patient. This allows them to respond accordingly to minor changes and accommodate for unexpected responses.

In empirical studies, empathetic nursing has been shown to both “enhance diagnostic accuracy” and reduce anxiety, depression, and hostility in cancer patients (Mercer and Reynolds S9). Positive correlations were found in nursing between empathy and communication skills in a 2018 study and between empathy and problem-solving skills in a 2020 study (Gimenez-Espert and Prado-Gascó; Ay et al.). This data all heavily supports the relationship between empathetic nursing and a heightened quality of patient care.

The Need for Training

It may seem that an occupation that requires so much interpersonal skill would be full of empathetic individuals, but nurses have a bad track record for allowing biases, closed-minded thinking, and a lack of emotional awareness to lead to the mistreatment of their patients.

Discrimination based on a patient's race, religion, weight, or age, are all common avenues by which unempathetic nurses abuse their power. “Continuing the conversation

in nursing on race racism” by Joanne M. Hall addresses the persisting effects that individual and systemic cases of racism have on black patients by white nurses. Hall advocates for raising consciousness of these issues and encouraging white or otherwise privileged nurses to confront their own biases and strive towards more equal treatment for black patients. A key element of this pursuit is empathy. Empathy allows us to step outside of ourselves and imagine a situation from the perspective of a patient who is fundamentally different. This exercise forces nurses to consider their patients as equals: real people with real pain.

One literature review found that there are generally low levels of empathy in registered nurses, and that this can have serious outcomes on the care for the client (Reynolds and Scott 226). In many studies reviewed, unempathetic nurses caused increased distress, leading to physiological responses such as hypertension and palpitations. Unempathetic nurses were also unable to understand their patients well. Lack of communication caused nurses to “fail to provide essential information” and “fail to provide emotional support” (Reynolds and Scott 230). These issues are widespread in health systems, and when combined with rampant racism, ageism, homophobia, fatphobia, and religious intolerance, they present a serious danger to patients whom these systems are intended to heal. Empathy training is an absolute necessity for addressing the shortcomings of nurses.

The most significant counterargument to the need for empathy training is that it may add too much pressure to nurses, contributing to compassion fatigue and burnout. While this may seem like a common-sense connection, many studies have ruled it out as a significant concern. In fact, empirical data suggests that empathy is actually a protective

factor that relieves stress and prevents burnout in nurses (Ren). Compartmentalization for the sake of distancing emotional responses to stress also removes the rewarding elements of patient care and leads to nurses resenting their jobs.

Empathy Training: How Does it Work?

There are a few methods to measure empathetic levels in nursing staff that have been used in studies in the past. These include mostly qualitative systems, such as patient response surveys and scales like the Jefferson Scale of Empathy and the Interpersonal Reactivity Index (IRI resources can be found in Appendix B). Using one of these methods to evaluate the levels of empathy that nurses currently display is a good first step in implementing empathy training.

Many studies have been conducted regarding the effectiveness of empathy training on nurses and nursing students. After a significant decline in patients' positive responses to surveys about their nurses' expression of empathy, a neurology floor implemented "Empathy Huddles", a specialized form of empathy training, throughout the day for nurses in one experiment. Nearly 2 years after the introduction of the training, positive patient response increased by 45% and nurses reported feeling more meaningful connections to their patients (Turner et al.).

Roleplay is another popular method of teaching empathetic practices, especially to nursing students. Many schools utilize clinical simulations and give students an opportunity to practice empathetic skills on "patients" in a low-stakes environment. A study done in 2018 found that the experimental group, which was exposed to empathy training, showed much more empathy according to the Jefferson Scale of Empathy in their subsequent evaluation than the control group (Larti et al.).

The synthesis of this research provides evidence that empathy training is a sound approach to improving patient-centered nursing care and addressing the issues described above. However, there is always a need for new methods to accomplish this goal.

Narrative Nursing to Improve Empathy

The method of empathy training that I will propose is unlike most that have been implemented in the past. While some studies have included reading and writing theatrical monologues, poetry, and fiction in their training, none have specifically focused on the principles of narrative nursing. A major benefit of the narrative medicine studies that have been done is the improvement of empathetic patient care. This is because physicians have been taught to pay close attention to the patient's self-telling as a narrative and to recognize the intersubjective relationship that is necessary for proper care. The purpose of this thesis is to adapt narrative medicine principles for empathy training to make them more accessible to nurses.

Magical realism, as was mentioned in the last chapter, has a special potential for encouraging empathetic growth in readers. One reason for this is the transportation of the reader into the mind and soul of characters, as most fiction does. The genre's use of liminal space heightens that experience and allows for the dismantling of binary hierarchies. Magical realism questions the meaning of experience and its impact on us. It puts us in new frames of mind and allows us to imagine how things could be in different scenarios. This quality of the genre has the potential to help nurses grow in their cognitive empathy abilities.

The guide that I am proposing with this thesis is for the use of individual nurses rather than a training program for a facility. Individual healthcare providers learning how

to practice empathy will not solve the systemic injustice in healthcare systems, but it can raise awareness of and address discriminatory behavior and the objectification of patients on a case-by-case basis. It will teach nurses who care about these issues the ways that they can help patients feel better served. In the future, when studies have been conducted using this system, if it is found to be effective, there are ways to adapt it for widespread training in facilities.

V. DISCUSSION

Introduction

With all necessary background information established, this section serves to synthesize the three topics discussed so far and target them towards the improvement of empathetic nursing practices. First, I provide a closer look at the discipline of narrative nursing. Then, I discuss the ways that reading magical realism can both promote empathy and be used in narrative nursing. Finally, I propose a guide that combines these concepts and takes nurses step by step through the process of self-taught empathy training via magical realism. In order to supplement the guide, I use examples from a close reading of the magical realism short story *The Handsomest Drowned Man in the World* by Gabriel García Márquez to demonstrate each step.

Narrative Nursing

The concept of narrative nursing does not stray far from the concept of narrative medicine. This discipline is simply the adaptation of ideas from narrative medicine to better fit the roles of a nurse. To reiterate the definition, narrative nursing is the application of narrative skills (close reading using narrative knowledge and the four areas of clinical care) to the nurse-patient encounter.

Robert Schleifer's model of narrative knowledge is so dynamic and flexible that it does not need to be modified to fit the nursing environment. Nurses can learn to recognize the narrative elements of the patient's self-telling and all other interactions by practicing reading fictional works. With the development of their skill, nurses will better be able to give their full attention to the patient, co-construct the narrative, and become

more sensitive to the nuances of the interaction. Treatment can be more personalized, collaborative, and empowering to the patient this way.

Nurses have more opportunities than physicians to practice intersubjectivity, dualism, thirdspace navigation, and bioethics, since they interact with patients more often and intimately. Intersubjective encounters are vital to building rapport and then trust between the patient and the nurse. By engaging with the patient's story and allowing them to play a role in their own therapy, nurses can dissolve the hierarchy that often leads to abuse of power in the clinic. Intersubjectivity in nursing is unique because of the amount of physical contact the job requires. Patients must trust their nurses, or else they may feel distressed and vulnerable during their therapy. Dualism in the context of narrative nursing requires nurses to consider the emotional and mental state in addition to the physical state of the patient in every single interaction. This means asking the patients directly how their mental health is doing, what emotions they are feeling, and how their treatment has impacted those factors. Part of a nurse's role that differs from a physician's is to provide consistent comfort, both physically and emotionally.

Navigating the unsettling transitional space of the patient experience is similar between medicine and nursing, with the only major difference being the heightened opportunity for nurses to relate to their patients and approach the thirdspace with empathy. Empathy plays a huge role in narrative nursing bioethics as well, in which nurses must make an active effort to treat all patients equally and fairly despite any personal differences or biases. The breakdown of power differences accomplished by intersubjectivity assists in this process as well.

Practicing narrative nursing involves closely reading fiction literature, identifying the elements of narrative, and reflecting on how this practice could influence understanding of the concepts of intersubjectivity, dualism, thirdspace, and bioethics. Applying narrative nursing involves the intentional consideration of each of those four concepts before, during, and after treatment by participating in active listening, identifying narrative elements, providing opportunities for patient participation, and consistently checking up on the patient's state. Next steps could also involve reflective writing to evaluate how well the concepts were applied in a patient encounter so that they can be improved in subsequent interactions. Each of these steps requires well-developed empathetic skills, which will also improve with these practices.

Magical Realism in the Nurse-Patient Encounter

Fiction in general is beneficial to empathetic nursing because it allows readers to see situations through the eyes and mind of another person, to observe relationships and dialogue, and to constantly make ethical judgements. Magical realism is a particularly promising genre because of the creation of liminal space, the necessary acceptance of uncertainty, and the dissolution of hierarchies, but there are also parallels to be drawn between the nurse-patient clinical encounter and the magical realism narrative.

We have already seen how all of Schleifer's elements of narrative are present in the clinic: the patient acts as a teller, organizing their story as a sequence of events involving recognizable agents such as characters and the states of health and illness, and iterates this story to the nurse, who acts as a listener. The two co-construct an ending to the narrative, along with other healthcare professionals, and by the ending, the nurse witnesses a shift that has occurred in the state of the patient throughout the experience.

But we can get more specific than this; the nurse-patient interaction is not just narrative. It is a magical realism narrative.

The most important defense for this point is the presence of liminal space in the clinical environment. Patients experience a merging of the ordinary world of health with the extraordinary world of illness when they undergo disease or injury. In serious cases, patients sit in a space between life and death. Healthcare professionals work solely in that liminal space, attempting to bring patients as close as possible to the ordinary world they became accustomed to pre-illness. Nurses work in a separate liminal space between the world of medicine and the world of the patient. They are the mediators who bring patient concerns to physicians and execute physician's orders for the patient. They often translate diagnoses and treatment plans into layman's terms to facilitate patient understanding. Nurses and patients are both liminal beings when they fill those roles; therefore, the nurse-patient encounter takes place in a liminal space.

The five primary characteristics of magical realism are all present to some degree or another in clinical interactions. Magic as it appears in magical realism does not play a role in nursing care, but this requirement can be met by other unobservable or extraordinary occurrences, which could still be considered somewhat fabulist. Examples of this include unconsciousness due to anesthesia or coma, phantom limb syndrome, near death experiences, inexplicable changes in a patient's state, etc. While these have scientific explanations, the experiences themselves are jarring and may seem miraculous or otherworldly to patients. Even experiences like the perception of pain could be considered an irreducible element here, since it is both a mental and physical experience that cannot be measured externally and must be communicated by the patient.

The phenomenological world is present in the empirical side of nursing care, involving lab tests and observable signs of illness. The observation of liminality has already covered the requirement for a closeness or merging of two worlds.

The patient may experience an oscillation between understandings of events as they feel symptoms and attribute them to their own understanding of disease while simultaneously learning the objective truths about pathophysiology. The patient's illness forcing them to depart to a degree from their "real" selves (the concept of thirdspace) is likewise an incongruence between understandings. This questioning of identity along with the awareness of time and how much of it is left in one's life fulfills the fifth requirement about challenging perceived ideas.

Magical realism literature has already been applied to the healing of trauma on a cultural level through postcolonial discourse and on an individual level through psychological counseling. It has powerful potential for many different types of healing, and it is time to explore the possibility of nurses utilizing it to bring more empathy to their patient care.

A Step-by-Step Guide: Magical Realism Empathy Training for Narrative Nursing

I will now propose a guide for empathy training that takes nurses step-by-step in closely reading magical realism literature, reflecting on it, and practicing narrative and empathetic skills in patient encounters. Supplementing each step is an example of how this could be applied. For the sake of the example, suppose that I am a nurse who has received feedback of patient dissatisfaction from my supervisors. I want to correct this, so I have decided to train myself in narrative nursing using this guide.

1. Evaluate your current level of empathetic skills

Complete an empathy measurement survey such as the Interpersonal Reactivity Index (IRI). This is not the most updated or accurate way to measure empathy, but it is accessible and a helpful tool for self-evaluation. A copy of the survey and the national result means can both be found in Appendix B.

Example: My initial results indicated that I have no trouble imagining myself in fictional scenarios, but I do not tend to spontaneously put myself in other people's shoes. I am slightly below the average rate of empathetic concern for others in difficult situations, and I do not naturally feel distressed when I am around others who are distressed. It seems that some of my biggest issues in patient interactions must come from my inability to see the situation from their perspective. I do feel concern and a desire to understand them (emotional empathy), but I am not skilled in cognitive empathy, which limits my ability to demonstrate behavioral empathy.

2. Choose a piece of magical realism literature and read it attentively

As stated before, this can be any piece of fiction that contains magical realist elements. A list of magical realism texts can be found in Appendix A, or you could apply Faris' primary characteristics to determine for yourself if a text you've chosen fits the genre.

Example: I will be reading the short story *The Handsomest Drowned Man in the World* by Gabriel García Márquez. It tells of a remarkably large and attractive man's corpse that has washed ashore in a village. The inhabitants become attached as they clean him up, clothe him, and put on a funeral. Once they return his body to the sea, the villagers are so moved by the life they have imagined for the man that they find new purpose in their own lives, plant flowers throughout the town, and join in community.

3. Identify elements of narrative

The six elements of narrative are (1) a sequence of events, (2) recognizable agents/characters, (3) an end, (4) a teller and a listener, (5) a witness, and (6) an experience/shift.

Example: (1) Children see the drowned man wash up on shore and start to play with him. The men of the village leave to try to find out where he came from while the women clean him up. The women become attached to him, fabricating a life and giving him the name Esteban. The men return without answers and become equally attached. In gathering flowers from neighboring villages for the funeral, the women bring back more and more people to witness it. The villagers become aware amidst the extravagant display

that their small village had become desolate over the years, and decide to bring it back to life for the sake of the drowned man.

(2) The characters are the men, women, and children of the island and surrounding area and “Esteban”, the drowned man.

(3) The story ends with a description of the way the town has changed since the funeral.

(4) Either García Márquez or the narrator is the teller and I am the listener, although the dedication reads “a tale for children”, which suggests that children are the intended audience.

(5) There are a few witnesses here; I am one, since I observed the entire story play out. The neighboring villagers also witness the transformation of the island due to the drowned man.

(6) The experience of meeting, caring for, and sending off the drowned man meaningfully impacts all of the characters in the story, especially the villagers. The change of physical appearance in the man as he is washed and clothed mirrors the change of heart in each of the villagers as they empathize with this stranger who has no way of expressing emotions.

4. Identify the primary characteristics of magical realism

The primary characteristics of magical realism are (1) the irreducible element of magic, (2) detailed descriptions of the real world, (3) oscillation between understandings of events, (4) merging of two worlds, and (5) questioning the way we think about time, space, or identity.

Example: (1) The drowned man is superhuman in his size and beauty. His presence casts a strange, subtle enchantment over the villagers who care for him.

(2) The desolation of the village before the man's arrival is described in detail as well as the dirtied state of the man when he arrives. Likewise, the sensory imagery of the village during and after the funeral is remarkable.

(3) I as a reader have a difficult time understanding whether there was something supernatural at play in the affection of the villagers towards the man or there is another explanation. It runs so deep that they completely alter their way of life after sending him off.

(4) The world of this strange man is introduced to the world of the villagers. Then, at his funeral, the worlds of neighboring villages are brought together. More abstractly, death is brought into a living town, and that merging causes them to live their own lives more fully.

(5) Identity is a theme in this story, as the villagers who know nothing of this stranger form a complete identity for him and then fall in love with it. The perfection of this "Esteban" that they craft together is later challenged when they wonder if his great size and strength made his life difficult and if it made him lonely. The theme could translate to the real world in the ways that we assume the identities of others based on initial perceptions. We cannot know their struggles, values, or personalities based on their appearance, and it can be dangerous to firmly assume that our impressions are correct, especially if we treat people differently based on them.

One more important note about this story is the presence of some magical realism variations. The abnormal size of the drowned man falls under grotesque realism and the reflection of the mood of the villagers on the landscape falls under mythic realism.

5. Consider any ethical or moral implications of the story

Practice making ethical judgements by determining whether the actions of the characters were just or unjust, and ways that they could have been more ethical.

Example: The children at the beginning of the story play with the dead man, which is disrespectful to his memory. The villagers feel a moral duty to care for this man, and they all put their lives on hold and went out of their way to help put him to rest. It is a beautiful, righteous action that they collectively decided to do. However, they let their physical evaluation of the drowned man form his complete identity in their minds, which in some ways dehumanizes him. He becomes an object, or a trophy, that they feel honored to care for. If they considered him a whole person from the beginning, acknowledging that they do not know him, it would have been more ethical.

6. Practice empathizing with the characters

Attempt to set aside your own perspective and put yourself in the place of the characters. The more you practice this, the stronger your cognitive empathetic skills will become.

Example: It was easy for me to judge the children at the beginning of the story for playing with the drowned man as if he were an object. However, I am not currently a child, and if I were, I may not have understood what death means and that he should be

treated with respect. I also can relate to the characters who desire to clean up and clothe this stranger, since I am a nurse and that is what I love to do. I think I may sometimes objectify my patients by allowing my impressions of them to inform their whole character. If I were in this story, I probably would have done the same thing the women did in creating a life for him based on his appearance. They also may have felt emotional because of the presence of death. I imagine there was a deep sadness at the thought that they would never get to speak to this man, and that is why there was so much mourning at his funeral.

7. Consider how these observations could impact areas of clinical care

Think about each of the answers you have given so far and try to make connections with (1) intersubjectivity, (2) dualism, (3) transitional space, and (4) bioethics in a nursing environment.

Example: (1) Since the man was dead when he entered into the women's care, he was not able to be active in the construction of his patient narrative. When I have the opportunity to speak with my patients and learn their perspectives, I should make an active effort to engage them in their therapy.

(2) The village slowly realized in caring for this man's body that he also had an entire life that they did not know about. I as a nurse have the opportunity to learn about my patients' identities from them, which will allow me to see them more as minds, bodies, and souls together. That will help me treat them the way they deserve to be treated.

(3) This story has a strange tone, as it seems like an impossible situation and the theme of death is prevalent. This discomfort and departure from reality must be somewhat like

what my patients feel while they are in a diseased or injured state. I can make more of an effort to meet them where they are in their fear or pain rather than expecting them to act normally in an abnormal situation.

(4) This story carries the theme of respecting someone for the sake of themselves rather than their appearances. This idea could help me to confront my biases or immediate assumptions about people based on their age, race, religion, or size so that I can provide them more just care.

8. Take time before patient interactions to remember to practice this

Remind yourself of whatever lessons you learned through this exercise. Ask yourself how you can apply them to this particular encounter. Take action.

Example: Before walking into a patient's room in the ER, I took a moment to remember this story. This is what I told myself: this patient is a person with a life outside of the hospital. This is an uncomfortable situation for her. I can be sensitive to her emotions and show her that I am listening to her so that she feels a little safer and like she can trust me. I will not allow initial impressions to form my judgement of her character.

When I walked in, the patient yelled at me for taking so long to see her. At first, I was indignant. I acknowledged her emotions internally, then put myself in her place to see how she might be feeling. I acknowledged her feelings out loud and then apologized for causing her to feel upset. I told her that I was here to help her and I would do everything I could to make her comfortable. Then, I asked her for her chief complaint and her chief concern, elaborating when she had questions. She calmed down shortly and was able to express the reasons she got so upset. I paid close attention to her illness narrative, then

explained the triage procedures I was doing so that she understood. I asked her if it was okay for me to put on her blood pressure cuff and pulse oximeter before I touched her. The tension that filled the room when I walked in subsided as we began to build a mutually trusting relationship.

9. Reflect on the encounter afterwards

Take some time at the end of the day to reflect on how your efforts went. You will still make mistakes sometimes, but learning from them is an important part of nursing.

Example: Writing out a patient encounter like the example for 8 is a helpful way to see how my techniques worked well or how I could do better next time. I could also ask the patient if I was meeting her needs well.

10. Evaluate your level of empathetic skills (again)

After practicing this method for a while, you can take the IRI survey again and see if your answers have changed at all. This is an optional step if you want more feedback on your growth.

Example: After taking the IRI survey again, my perspective-taking scale has risen a lot. I have started to get used to setting aside my point of view to think about why people may be feeling what they are feeling, and my patients seem more satisfied with their care. I thought it might be stressful to keep all of these things in mind, but I actually enjoy my job more now than I did when I started this.

VI. CONCLUSION

This research addresses the issues of objective and unjust patient care in nursing by proposing a method of empathy training that applies principles of narrative medicine to the reading of magical realism literature. Illuminating connections drawn between narrativity, liminal space, and empathy suggest that closely reading magical realism using narrative nursing techniques is an effective avenue for individual nurses to improve their empathetic patient care.

The narrative nature of the clinical encounter is especially significant for nurses to acknowledge in order to treat their patients well. This can be highlighted by considering the principles of intersubjectivity, dualism, thirdspace, and bioethics. Reading fiction is an effective method for practicing narrative knowledge in order to better apply it to patient-centered care.

Magical realism's utilization of liminal space sets it apart from other genres as a mode of questioning reality and encouraging empathetic practices in readers. Magical realist authors merge the worlds of fantasy and reality, dissolving hierarchies and challenging accepted societal norms. This liminal nature can also be seen in the patient experience and the nurse's role in it, making magical realism especially fitting as a genre to be used in narrative nursing training.

Emotional, cognitive, and behavioral empathy can be measured and trained to improve nursing care. Learning narrative nursing theory and reading magical realism literature are both effective ways to practice and improve empathetic skills. When those two methods are combined, the outcomes can be even more significant for nurses.

The literature reviews and chapter on empathy included in this thesis inform readers of the basic principles of these concepts so that they can be utilized in the step-by-step guide without any formal education or training. This is just a preliminary step, opening the door to more research on these powerful connections. In the future, experiments should be conducted to test the effectiveness of this specific guide so that it can be adjusted and refined to better suit its purpose. Following that research, steps should be taken to create more widespread, accessible training programs for nurses so that they do not have to teach the theory to themselves. This research can also be expanded into other professions in the healthcare field that require empathetic enhancement and other genres of literature that some individuals may find more effective in their own experience.

Very little research on narrative nursing has been conducted at all. This thesis is an innovative contribution to the field that will hopefully spark a more focused dialogue in the healthcare world. Narrative nursing and magical realism hold the keys to learning what it means to treat people with dignity and compassion. Patients deserve to be known as more than their illnesses and nurses have a responsibility to learn the story beneath the skin.

APPENDIX A:
LIST OF MAGICAL REALISM TEXTS

- Isabel Allende: *Eva Luna*; *The House of the Spirits*; *The Stories of Eva Luna*
- Jorge Amado: *Dona Flor and Her Two Husbands*; *The War of the Saints*
- Ron Arias: *The Road to Tamazunchale*
- Marcel Ayme: *The Man Who Walked Through Walls*
- Aimee Bender: *The Particular Sadness of Lemon Cake*
- Jorge Luis Borges: *The Aleph and Other Stories*; *Ficciones*; *Labyrinths*
- Ray Bradbury: *Dandelion Wine*
- Mikhail Bulgakov: *The Master and Margarita*
- Dino Buzzati: *The Tartar Steppe*
- Italo Calvino: *The Baron in the Trees*; *If On A Winter's Night A Traveler*
- Alejo Carpentier: *Explosion in a Cathedral*; *The Kingdom of This World*
- Angela Carter: *Nights at the Circus*
- Ana Castillo: *So Far From God*
- Syl Cheney-Coker: *Sacred River*
- Otar Chiladze: *A Man Was Going Down the Road*
- Julio Cortázar: *Hopscotch*
- Edwidge Danticat: *Claire of the Sea Light*
- Anthony Doerr: *The Shell Collector*
- Mariana Enríquez: *Things We Lost in the Fire: Stories*
- Louise Erdrich: *Love Medicine*; *Tracks*
- Laura Esquivel: *The Law of Love*; *Like Water for Chocolate*
- Carlos Fuentes: *Distant Relations*
- Neil Gaiman: *American Gods*; *The Ocean at the End of the Lane*
- Cristina García: *Dreaming in Cuban*
- Nikolai Gogol: *The Nose*
- Gunter Grass: *The Tin Drum*
- Lauren Groff: *The Monsters of Templeton*
- Yaa Gyasi: *Homegoing*
- Mosin Hamid: *Exit West*
- Joanne Harris: *Chocolat*
- Alice Hoffman: *The River King*
- Zora Neale Hurston: *Their Eyes Were Watching God*
- Kazuo Ishiguro: *The Buried Giant*; *Never Let Me Go*
- Eowyn Ivey: *The Snow Child*
- William Kennedy: *Ironweed*
- Nicole Krauss: *Forest Dark*
- Ibrahim al-Koni: *The Bleeding of the Stone*
- Milan Kundera: *The Book of Laughter and Forgetting*
- Kojo Laing: *Search Sweet Country*
- Kelly Link: *Magic for Beginners*

- Gabriel García Márquez: *Chronicle of a Death Foretold*; *Love in the Time of Cholera*; *One Hundred Years of Solitude*; *Short Stories*
- Yann Martel: *Life of Pi*
- Anna Marie McLemore: *When the Moon Was Ours*; *Wild Beauty*
- Meg Medina: *The Girl Who Could Silence the Wind*
- Erin Morgenstern: *The Night Circus*
- Toni Morrison: *Beloved*; *Paradise*; *Song of Solomon*; *Tar Baby*
- Haruki Murakami: *Hard-Boiled Wonderland or the End of the World*; *Kafka on the Shore*; *The Wind-Up Bird Chronicle*
- Vladimir Nabokov: *Pale Fire*
- Téa Obreht: *The Tiger's Wife*
- Ruth Ozeki: *A Tale for the Time Being*
- Ben Okri: *The Famished Road*; *Songs of Enchantment*; *Infinite Riches*
- Helen Oyeyemi: *The Icarus Girl*
- Orhan Pamuk: *Snow*; *The White Castle*
- Loida Maritza Pérez: *Geographies of Home*
- Ishmael Reed: *Mumbo Jumbo*
- Tomas Rivera: *...And the Earth Did Not Devour Him*
- Arundhati Roy: *The God of Small Things*
- Juan Rulfo: *Pedro Páramo*
- Salman Rushdie: *Haroun and the Sea of Stories*; *Midnight's Children*; *The Satanic Verses*
- Karen Russell: *Swamplandia!*
- Erick Setiawan: *Of Bees and Mist*
- Ryhaan Shah: *Weaving Water*
- Zadie Smith: *White Teeth*
- Amy Tan: *The Bonesetter's Daughter*
- D.M. Thomas: *The White Hotel*
- Ngũgĩ wa Thiong'o: *Wizard of the Crow*
- Daniel Wallace: *Big Fish*
- Virginia Woolf: *Orlando*; *The Waves*
- Karen Tei Yamashita: *Through the Arc of the Rainforest*
- Tiphonie Yanique: *Land of Love and Drowning*; *How to Escape from a Leper Colony*

APPENDIX B:

INTERPERSONAL REACTIVITY INDEX SURVEY

This survey was found on Eckerd College's website ("Interpersonal").

The following statements inquire about your thoughts and feelings in a variety of situations. For each item, indicate how well it describes you by choosing the appropriate letter on the scale at the top of the page: A, B, C, D, or E. When you have decided on your answer, fill in the letter on the answer sheet next to the item number. **READ EACH ITEM CAREFULLY BEFORE RESPONDING.** Answer as honestly as you can.

ANSWER SCALE:

A	B	C	D	E
DOES NOT				DESCRIBES ME
DESCRIBE ME				VERY WELL
WELL				

- I daydream and fantasize, with some regularity, about things that might happen to me. (FS)
- I often have tender, concerned feelings for people less fortunate than me. (EC)
- I sometimes find it difficult to see things from the "other guy's" point of view. (PT) (-)
- Sometimes I don't feel very sorry for other people when they are having problems. (EC) (-)
- I really get involved with the feelings of the characters in a novel. (FS)
- In emergency situations, I feel apprehensive and ill-at-ease. (PD)
- I am usually objective when I watch a movie or play, and I don't often get completely caught up in it. (FS) (-)
- I try to look at everybody's side of a disagreement before I make a decision. (PT)
- When I see someone being taken advantage of, I feel kind of protective towards them. (EC)
- I sometimes feel helpless when I am in the middle of a very emotional situation. (PD)
- I sometimes try to understand my friends better by imagining how things look from their perspective. (PT)
- Becoming extremely involved in a good book or movie is somewhat rare for me. (FS) (-)
- When I see someone get hurt, I tend to remain calm. (PD) (-)
- Other people's misfortunes do not usually disturb me a great deal. (EC) (-)
- If I'm sure I'm right about something, I don't waste much time listening to other people's arguments. (PT) (-)
- After seeing a play or movie, I have felt as though I were one of the characters. (FS)
- Being in a tense emotional situation scares me. (PD)
- When I see someone being treated unfairly, I sometimes don't feel very much pity for them. (EC) (-)

- I am usually pretty effective in dealing with emergencies. (PD) (-)
- I am often quite touched by things that I see happen. (EC)
- I believe that there are two sides to every question and try to look at them both. (PT)
- I would describe myself as a pretty soft-hearted person. (EC)
- When I watch a good movie, I can very easily put myself in the place of a leading character. (FS)
- I tend to lose control during emergencies. (PD)
- When I'm upset at someone, I usually try to "put myself in his shoes" for a while. (PT)
- When I am reading an interesting story or novel, I imagine how I would feel if the events in the story were happening to me. (FS)
- When I see someone who badly needs help in an emergency, I go to pieces. (PD)
- Before criticizing somebody, I try to imagine how I would feel if I were in their place. (PT)

NOTE: (-) denotes item to be scored in reverse fashion

PT = perspective-taking scale

FS = fantasy scale

EC = empathic concern scale

PD = personal distress scale

A = 0

B = 1

C = 2

D = 3

E = 4

Except for reversed-scored items, which are scored:

A = 4

B = 3

C = 2

D = 1

E = 0

Means and Standard Deviations for the Four IRI Scales

(Catalog of Selected Documents, 1980, 10, 85)

	<u>Males (N = 579)</u>	<u>Females (N = 582)</u>
Fantasy	15.73 (5.60)	18.75 (5.17)
Perspective Taking	16.78 (4.72)	17.96 (4.85)
Empathic Concern	19.04 (4.21)	21.67 (3.83)
Personal Distress	9.46 (4.55)	12.28 (5.01)

APPENDIX D:
PRINTABLE STEP-BY-STEP GUIDE

1. Evaluate your current level of empathetic skills

Complete an empathy measurement survey such as the Interpersonal Reactivity Index (IRI).

2. Choose a piece of magical realism literature and read it attentively

This can be any piece of fiction that contains magical realist elements. A list of magical realism texts can be found in Appendix A, or you could apply Faris' primary characteristics to determine for yourself if a text you've chosen fits the genre.

3. Identify elements of narrative

The six elements of narrative are (1) a sequence of events, (2) recognizable agents/characters, (3) an end, (4) a teller and a listener, (5) a witness, and (6) an experience/shift.

4. Identify the primary characteristics of magical realism

The primary characteristics of magical realism are (1) the irreducible element of magic, (2) detailed descriptions of the real world, (3) oscillation between understandings of events, (4) merging of two worlds, and (5) questioning the way we think about time, space, or identity.

5. Consider any ethical or moral implications of the story

Practice making ethical judgements by determining whether the actions of the characters were just or unjust, and ways that they could have been more ethical.

6. Practice empathizing with the characters

Attempt to set aside your own perspective and put yourself in the place of the characters.

The more you practice this, the stronger your cognitive empathetic skills will become.

7. Consider how these observations could impact clinical care

Think about each of the answers you have given so far and try to make connections with (1) intersubjectivity, (2) dualism, (3) transitional space, and (4) bioethics in a nursing environment.

8. Take time before patient interactions to remember to practice this

Remind yourself of whatever lessons you learned through this exercise. Ask yourself how you can apply them to this particular encounter. Take action.

9. Reflect on the encounter afterwards

Take some time at the end of the day to reflect on how your efforts went. You will still make mistakes sometimes, but learning from them is an important part of nursing.

10. Evaluate your level of empathetic skills (again)

After practicing this method for a while, you can take the IRI survey again and see if your answers have changed at all. This is an optional step if you want more feedback on your growth.

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