

Contemporary Ideas

Narrative Competence: a neglected area in undergraduate curricula

Introduction: ~~Narrative competence~~

According to many inter-disciplinary scholars, including, notably, Alasdair MacIntyre and Jerome Bruner, human action and accounting for such action draws on and is shaped by available cultural narratives. Nursing is no exception to this truism, which makes the development of narrative competence in nursing a pressing curricular imperative. At a broad level, narrative competence refers to a finessed, ethically-charged respect for human lived and storied experience. At the level of professional development, it demands that nurses must constantly strive to improve on their abilities around listening, hearing, absorbing, interpreting, and intelligently responding to the stories of people in their care (Bach and Grant 2015). Doing so facilitates empathic, and trustworthy practice through sensitive attunement to existential qualities such as inner hurt, despair, hope grief, and moral pain. All of these qualities accompany, and sometimes constitute, the health problems that patients experience, and are of course more fundamentally inscribed within the human condition.

On the basis of our experience and scholarship in this area, we thus find the relative neglect of narrative competence in nursing educational policy, undergraduate nursing curricula, professional and educational literature, and related teaching practice surprising. Such neglect is made all the more remarkable in the light of recent very promising conceptual and practice developments in this area of healthcare. The contemporary turn towards fostering a more 'narratively competent' healthcare practitioner has been recently illustrated in the work of promoting narrative medicine (eg Charon 2006), narrative psychiatry (Thomas 2014), and narratively competent evidence-based nursing (Bach and Grant, 2015).

From the perspective of nurse educational policy in the UK and Ireland, the important skill of listening to patients and attending to what is said by them is predominantly addressed in its communication and interpersonal skills curricular elements (Bach and Grant 2015). Such competence is articulated as an essential requisite required for professional registration in Ireland and the UK. However, it is arguably complacent of nurse educators to assume that attainment of these competencies reflects and reaches the necessary educational depth required for skilled narratively competent practice. We make this assertion on the basis of our respective lived, academic experiences of many nursing students in our own and other

universities, and their qualified colleagues in practice, who seem ill-prepared to adequately understand, interpret and respond to the distress stories of people in their care.

The need for narrative competence in nursing practice

Nurses generally hear a multiplicity of stories from patients regarding the causes of illnesses or injuries which at times don't match the nature of their presentation, or biomedical explanations. This makes critical sensitivity to the context of the stories people tell nurses a crucially important area in understanding patients' sense making and the significance of this for their health and healthcare. This well illustrated in mental health nursing contexts, where narrative competence is central in uncovering the meanings – thus social contextual determinants – behind severe psychological distress (Johnstone 2014; Thomas 2014), and in harnessing the power of life 're-storying' as emancipatory and recovery practice (Grant and Zeeman 2012; Grant and Leigh-Phippard, 2014; Grant et al in press).

At a general level, Johnstone (2014) trenchantly argues the extent to which social context is absent from the now discredited, but still highly influential, diagnostic systems informing mainstream psychiatric practice, and how this is mirrored in mental health nurses and other workers' relative disinterest in social context. Thomas (2014) supports and extends this position in describing a consensus view in critical psychiatry over the last 15 years that the science behind mainstream biomedical views of 'mental illness' has rendered the lived experiences of extreme distress, and their interpretation by nurses and others, redundant in 'madness as brain disease' positions.

The need for greater levels of nursing narrative competence is perhaps nowhere more pressing than in responding to suicide narratives. This assertion is made on the grounds of Grant's experience of leading narrative inquiry in this area (Grant et al 2013), and his subsequent public presentations and ensuing dialogue, developing from this work. Suicide survivors and those who have witnessed suicide, or have been left to pick up the pieces following the successful suicide of a loved one, often voice how difficult it is to find narratively competent healthcare professionals. They express problems around achieving and sustaining emotional connection with nurses and others, who often want to talk about suicidal ideation and events in distanced, rationally-focused ways. They also experience health workers trying to shut them up or 'jolly' them out of suicide talk, or by attempting to invoke guilt in them by talking about the people that will be left behind. Further, at the level of an

over-arching response to suicide stories, health professionals frequently seem to want reduce the dialogue to a limited set of moral binaries, such as ‘life good/suicide bad’; ‘living rational/suicide irrational’. This constitutes the antithesis of narrative competence since it tends to close down helpful dialogue between health workers and the people they purport to help.

Respectful interpretation: a core aspect of narrative competence

In marked contrast, the interpretation of patients’ stories demands extraordinarily focused and careful, empathically-attuned levels of attention to them. The fact that ‘sometimes people hear so lightly what others say intensely, and sometimes people hear so intensely what others say so lightly’ (Plummer 2005¹ p 42) suggests the need for a superordinate skill that goes beyond the level of ‘active listening’ – often referred to in communication and interpersonal skills nurse educational literature.

Given the fact that nursing is always implicated in the interruption of patients’ life stories, the consequences of not sensitively and contextually interpreting narratives or recognising the need for this can be grave. In relation to mental health nursing for example, Grant and Leigh-Phippard (2014) and Grant et al (in press) have argued that service user narratives are often ignored, trivialised or marginalized. In contrast, these authors assert that the dominant narratives of institutional psychiatry trap users in stories told about them that neither accord with users’ lived experiences nor are respectful to those experiences. This points to the tensions between ‘meta-narratives’, or big stories, told by professional groups and local stories told by individuals in relationships with others. These tensions point to politics of narrative explanations in health care, around the dangerous consequences of institutional big stories achieving dominance in defining and colonizing users’ identities, and in compromising their life stories.

Respecting life stories

Our life stories inextricably link identities, beliefs and values with life experiences to date. For each of us, our life story has a distinct beginning and middle and end and is continually shaped by markers such as key friendships, work, migration, partnerships and marriages, illness and loss. Being sensitively attuned to someone’s life story enables a nurse to gain a deep, finessed and sophisticated understanding of that which is important to them and why they react and respond to illness, diagnosis and institutional care and treatment in the way

that they do. However, given our argument so far, in health care environments where personal context and meaning are de-privileged, such necessary levels of attunement are often lacking (Bach and Grant, 2015, Grant and Leigh-Phippard 2014; Grant et al. in press).

The price paid for this is the 'stuck lives' of many health and mental health service users. At the level of their identities, interruption of life narratives is not just a product of illness, but is also a consequence of institutional care and treatment. Defensive healthcare organisational responses often result in the stories people tell about their negative experiences of health interventions being regarded by nurses and others as false, or simply trivialised as 'anecdota' or as symptomatic of their mental health problems (Grant and Leigh-Phippard 2014, Grant et al in press).

Re-storying narrative identity

In contrast, narratively competent nursing can be transformative. The therapeutic benefits of nurses' deeply respectful engagement with their lived experience narratives of people in their care can include helping them re-story their lives into the future. Narrative re-storying facilitates reflexive engagement of people with their lives, their position in the world and the future shaping of their identities (Grant et al in press), and, perhaps more significantly re-story these identities. This is particular prescient given that the experience of serious and extreme psychological problems, encounters with suicide, or physical illness causes great biographical disruption (Grant and Leigh-Phippard 2014, Grant, Leigh-Phippard and Short in press; Grant et al. 2013).

A call for Narrative Competence and professional artistry

The ethical charge for nurses to help the people in their care re-story their lives points to the broader context of nurses' professional development. Bach and Grant (2015) argue that professional artistry is neglected in contemporary healthcare environments that privilege what Schon and others describe as technical-rational interventions. Perhaps the educational equivalent of 'painting by numbers', technical-rational training (as opposed to education) can be contrasted with education grounded in professional artistry. Broadly, technical-rational competencies are constructed on the basis of one size fits all, lack and neglect context and depth, and place little demand on practitioners for personal, professional, cultural and critical reflexivity. Professional artistry knowledge and skills are, in contrast, contextually finessed and nuanced, and demand corresponding reflexive awareness.

When applied to the area of narrative competence, a technical-rational, algorithmic training approach to learning communication and interpersonal skills frequently results in ‘clunky’ amateurish interventions. As argued earlier in specific relation to suicide dialogues, these are often experienced as disingenuous and/or facile by people in receipt of healthcare more broadly (Bach and Grant 2015). In contrast, the professional artistry of narrative competence aims for deeper levels of meaningful emotional connection between nurses and the people in their care, which can facilitate identity re-storying in the latter group. To paraphrase Charon (2006), such connection increases ethicality between the subjectivities of nurse and patient or service user, in the service of healing. Moreover, as a direct challenge to technical-rational healthcare interventions, interviews with patients and users focus less on algorithmic grids of questions and more on open-ended dialogue.

In light of the above, we believe that our call for undergraduate nurse higher education that pays more respect to narrative competence is thus timely and necessary. This has crucial implications for the need to revise and develop nursing curricula accordingly, and to prepare nurse educators for the task in hand.

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