**Contemporary Ideas**

# Narrative Competence: a neglected area in undergraduate curricula

## Introduction

According to many inter-disciplinary scholars, including, notably, Alasdair MacIntyre and Jerome Bruner, human action draws on and is shaped by available cultural narratives. Nursing is no exception to this fact, and it is this which has prompted the creation of this paper which argues that the development of narrative competence in nursing ought to be 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 attending, interpreting and intelligently responding to the stories of people in their care (Charon 2007, 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 the health problems that patients and clients experience, and are of course more fundamentally inscribed within the human condition.

Whilst the notion of narrative pedagogy as an educational strategy within nursing is not new in the international educational literature (e.g. Brown et al 2008, Wood 2014, Ironside 2015), on the basis of our experience and scholarship in this area, we find a relative neglect of narrative competence in nursing educational policy, undergraduate nursing curricula and professional and educational literature. For example, a thorough search of CINAHL Complete combining the search terms ‘narrative competence’ and ‘nursing’, yielded only 4 papers. Such neglect is made all the more remarkable in the light of recent very promising conceptual and practice developments in this area of healthcare. Clearly, there is a greater need for research in this area relating to narrative awareness and narrative competence. The contemporary turn towards fostering a more ‘narratively competent’ healthcare practitioner has been recently illustrated in the work of promoting narrative medicine (e.g. Charon, 2006, 2007), 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 clients, 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 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 the people in their care 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 told by patients to 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., 2015). In general nursing contexts, attention to interpreting stories enhances the quality of care received by patients (Edwards 2001).

At a general level, Johnstone (2014) argues the extent to which social context is absent from the now discredited, yet influential, diagnostic systems informing mainstream psychiatric practice. This is potentially mirrored in mental health nurses' 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 the interpretation of lived experience, by nurses and others, redundant.

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 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' and clients' 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 2005, p. 42) suggests the need for a superordinate skill that goes beyond the level of 'active listening' – the latter often referred to in communication and interpersonal skills within nurse educational literature.

Charon (2007) usefully classifies three techniques of narrative competence: representation, attention and affiliation. Narrative representation relates to competence in examining narratives through texts and is most closely aligned with narrative pedagogical strategies in education. Competence here is potentially measureable via assessment of written or spoken interpretations of pre-set stories (e.g. Wood 2014). Narrative attention (which involves respectful interpretation) and affiliation (the making of a connection with the story) relate to the actual conduct (or professional artistry) of nursing, and it is this which we feel is lacking in curricula internationally. These techniques and subsequent competence arising from this kind of 'narrative nursing' can be initially addressed within educational programmes, yet are ultimately measurable as practical nursing competencies, evidenced through the nurse's ability to interpret and attend to the stories their patients and clients present.

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. (2015) 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 their lived experiences nor are respectful to those experiences. This illustrates the tensions between 'meta-narratives', or big stories, told by professional groups and local stories told by individuals in relationships with others. These tensions in turn highlight the politics of narrative explanation in health care, around the dangerous consequences of institutional big stories achieving dominance in influencing users' identities and 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 a person'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., 2015).

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 'anecdata' or as symptomatic of their mental health problems (Grant and Leigh-Phippard, 2014, Grant et al., 2015). It could be argued that such lack of personalisation also resonates with staff who have equally eroded identities within the larger institution, but this is outside the scope of this paper.

In contrast, narratively competent nursing can be transformative. The therapeutic benefits of nurses' deeply respectful engagement with the lived experience narratives of people in their care can include helping those people re-story their lives into the future. This could also be potentially transformative for nurses, given the reflexive nature of such narrative affiliation (Charon 2007). Narrative re-storying facilitates the reflexive engagement of people with their lives, their position in the world and the future shaping of their identities (Grant et al., 2015).

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 et al., 2013; Grant et al., 2015).

**A call for Narrative Competence**

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 nurses' 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. 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.

We suggest that the inclusion of narrative competence in relation to the skills of attending to, affiliating with and understanding representations of life narratives, as described by Charon (2007), within nursing curricula is essential. The use of narrative pedagogy (e.g. Brown et al 2008, Wood 2014, Ironside 2015) is one means by which to foster such skills, but the specification of narrative competence within curricula is essential. Measurement and refinement of such competence can occur within educational systems, but ultimately it is best assessed at the interface of care within healthcare settings as an aspect of competency standards. Although some modification to practice assessment documentation, and necessary testing for validity, would naturally be required, we suggest that doing this will benefit both

students and supervising staff in raising awareness and fostering what we believe to be an essential element of nursing.

In light of the above, we believe that our call for an undergraduate nurse higher education that pays more respect to narrative competence is thus timely and necessary. It is acknowledged that inclusion of narrative competence within the nursing curriculum would not be without its challenges. Greater discussion of such challenges are outside the scope of this paper. However, the consequences not considering the inclusion of narrative competence runs a greater risk for the quality of nursing and 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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