Can Writing and Storytelling Foster Self-care?

A Qualitative Inquiry Into Facilitated Dinners

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Research into self-care practices suggests the need for conscientious and systematic support of nurses and other health care providers. The purpose of this study was to explore the impact of an innovative self-care initiative. The goals were to explore the experience of nurses and other health care providers participating in a reflective, creative nonfiction storytelling event called “Dinner and Stories” and the potential benefits and limitations of using an informal, storytelling model for self-care. A qualitative narrative design was used. Twenty-seven participants including nurses, social workers, and hospice volunteers wrote creative nonfiction stories about a lingering experience of providing care. At predefined dates, groups of up to six met for dinner in a home setting. Participants read aloud, listened deeply, and discussed their narrated stories. Four sources of data were collected: creative nonfiction stories, online forum discussions, in-depth interviews, and host facilitator field notes. Researchers identified four themes: (1) needing a self-care culture, (2) storytelling and writing as healing, (3) co-creating layers of connection, and (4) preferring face-to-face contact. Results add to knowledge about the therapeutic benefits of writing and storytelling for nurses and other health care providers including enriched meaning-making, emotional conveyance, and therapeutic connections between storytellers and listeners.

To tell a story establishes a relationship and unless we humans trust that a relationship can be established, we can't tell stories—it's like trying to breathe under water. To press that metaphor, where once I saw patients drowning, now I see all kinds of medical workers drowning.^{1(p52)}

Research into self-care practices suggests the need for conscientious and systematic support for nurses and other health care providers.²⁻⁵ Ideally, care for caregivers should target the mental, physical, emotional, spiritual, and social well-being of the individual, the team, and the organization.^{2,5} Research into self-care and the prevention of burnout for health care providers recommends preventative and prescriptive practices such as attention to diet, exercise, and rest.⁶ Although practices such as these are shown to strengthen resilience,⁷ they fall short in addressing deeper, emotional stressors that caregivers experience and serve as simplistic solutions that can result in blaming the victim.⁸ Reported levels of emotional distress and grief^{9,10} by health care providers caring for people with serious illnesses and at the end of life highlight the importance of incorporating self-care into caregivers' practices and workplaces.

BACKGROUND

Recent studies have explored creative processes such as storytelling and journaling as tools for professional caregivers to address their self-care needs.^{11,12} Writing creative nonfiction—a melding of autobiography, memoir, and personal journalism—holds promise in this area. According to Van Luven,¹³ creative nonfiction draws both its veracity and its vitality from two intersecting circles: the inner, intimate and private world of the author and the complex, public world beyond the writer's individual consciousness. In addition, “if the writer does his or her job properly...[she/he] brings inner and outer worlds together in prose which illuminates a larger issue.”^{13(pvii)} Real-life stories then not only help the tellers to cope but also link them to the broader chain of humanity by exploring essential life experiences.

The benefits of creative nonfiction and writing emotional disclosure are increasingly being studied; Riddle et al¹⁴ conducted a literature review and meta-analysis of research into the impact of writing emotional disclosure for unpaid

KEY WORDS

creative nonfiction, end-of-life care, qualitative inquiry, self-care, storytelling

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caregivers. Although the population differs from our participants, this recent meta-analysis reported associations of writing with positive outcomes including improved caregiver general psychological health and reduced trauma, particularly among those relatively new to the caregiving role.

In the past decade, there has been a remarkable interest in the potential benefits, importance, and role of storytelling in health care.¹⁵⁻¹⁷ Although most of the research into therapeutic writing is with populations living with chronic illness, trauma, and socially stigmatizing experiences,¹⁸ there is a growing interest in stories of health care providers.¹⁹ Despite the value of creative nonfiction as a tool for self-care, research remains limited, particularly within the context of end-of-life care.

Purpose of the Study

The study aimed to explore the impact of a self-care initiative, “Dinner and Stories” (DS), to understand the challenges and difficulties health care providers face when caring for dying patients and their families. The goals were to examine the experience of health care providers participating in a reflective, creative nonfiction storytelling event in promoting self-care and to explore the potential benefits and limitations of using an informal DS model of self-care (described below).

The DS Event

We provided participants an invitation and instructions for writing a creative nonfiction story about an experience that lingered from their work related to end-of-life care. This could be an unresolved issue—something that touched or was disturbing for the care provider or whatever was meaningful to narrate and share. At a predefined date, a group met for dinner in a home setting; a counselor with experience facilitating groups hosted the dinners. Most participants did not know one another, and a home setting was chosen to foster relaxation and an informal environment. Participants were introduced; a nourishing meal was served, followed by a facilitated session by the host. Participants were invited to read their stories aloud, listen deeply, and reflect on each other's narratives. Guidelines about anonymity, ethical considerations, and support for storytelling were provided earlier during recruitment with an emphasis on sharing the story rather than writing skills or a polished narrative. Six DS events were offered with participants in small groups ranging from three to six participants per event. An online forum was available for participants to continue to discuss their stories and anything arising for 1 month after the dinner event.

Participants

Twenty-seven health care providers including eight nurses, ten social workers, two counselors, and five hospice volunteers and music therapists participated in the study (Table 1). Twenty-five women and two men participated. Inclusion

TABLE 1 Participant Caregiver Roles

Participants	n	Institutional Setting
Nurses	4	Acute care
Nurses	3	Hospice/palliative care
Nurses	1	Residential care
Social workers	6	Acute care
Social workers	4	Residential care
Counselors	2	Hospice/palliative care units
Volunteers	5	Hospice/palliative care units
Other (author, research manager)	2	Hospice/palliative care, university

criteria were as follows: currently employed within the regional health authority or volunteering with hospice, previously or currently working with dying patients and their families at any site or institution, willing to write and share a story, and able to speak and write in English adequately to convey the meaning of their story. The study was approved by the university and health authority research ethics board.

METHODS

Recruitment Process

Participants were recruited through snowball sampling and information sessions during staff meetings at palliative care units, social work staff meetings, and home and community care units. The catchment area was an urban city and surrounding municipalities (within one health authority) including tertiary and community hospitals with palliative care units and residential care facilities.

Study Design and Theoretical Approach

A qualitative design using a constructivist perspective was used. Drawing on Kim,²⁰ language and stories were considered as forms for representing events, producing new experiences, communicating the rational and emotional, and bringing people into ethical relationships. A narrative, constructivist approach²¹ framed the study and is founded on the premise that individuals, groups, and cultures create understandings of reality and sustain these perspectives through the stories they tell.²¹ Stories are people's constructions and perceptions of events and as such can be a “window” into how individuals understand and make sense of what is happening to them.²² A narrative approach aligned with the interest of this study on storytelling as potentially therapeutic.

Data Collection

Four modes of data were collected: (1) stories written about a significant work situation that each participant brought

to the DS evening (later, stories were typed into a Word document), (2) online forum discussions arising from the dinner, (3) in-depth interviews conducted 2 to 4 weeks after the dinner evening, and (4) field notes by the host facilitator of dinner events. The in-depth interviews were conducted by a research assistant not known to participants. Interviews were held at a time and location mutually convenient for the interviewer and interviewee. Interviews lasted 60 to 90 minutes and were recorded and transcribed verbatim. The interviewer used semistructured questions guided by exploratory, contrasting, and descriptive prompts to explore the experience of meaning-making through writing their story, reading to the group, and the overall experience of participating in the DS event. Sample interview questions were “Please tell me what prompted you to participate in the DS evening,” “Tell me about how you selected what story to tell,” “What was it like developing your story?”, “What was your experience of telling and sharing your story at the dinner?”, and “What is the overall impact of participating in DS?”. The focus of this article is on the process and perceptions of the DS event.

Data Analysis

Data were analyzed using thematic analysis.²³ Stories, online postings, transcribed interviews, and field notes were read several times by each researcher to identify recurring, converging, and opposing storylines and patterns. Preliminary themes were developed and used to further categorize and code the data. Comparisons of transcripts coded by each team member identified areas of similarities and

differences with possible links to theory. The software program Atlas-ti, designed for qualitative data, was used for data management.

RESULTS

While we will be presenting the nature of creative nonfiction stories in a future article, findings about self-care and the process of the DS event are presented here. Four main themes describe participants’ perceptions and experiences of the DS event: (1) needing a self-care culture, (2) storytelling and writing as healing, (3) co-creating layers of connection, and (4) preferring face-to-face contact (Table 2). Each theme with subthemes is presented hereinafter, beginning with the context of a self-care culture in health care.

Needing a Self-care Culture

Institutional priorities of caring for caregivers were experienced as developing slowly despite the rhetoric of staff support. An overall perception of participants was that maintaining fitness to practice is a shared responsibility between the employee and the employer; yet, an institutional culture of care is still lacking. As one social worker shared, “I think it’s a huge problem with our system because they just think you have to do better at taking care of yourself, without building that in” (1), and a nurse stated, “When anything big happens...you just have to put on a brave face” (2).

In particular, nurses and social workers expressed how the nature of their work obligates greater institutional

TABLE 2 Themes and Subthemes

Themes	Description	Subthemes
Needing a self-care culture	Ongoing absence of institutional priorities of care for caregivers. Nature of the caregiving requires greater institutional support.	1. Death: a difficult topic outside work
		2. Self-care practices remain an individual responsibility.
		3. Health care system does not support a culture of self-care.
Storytelling and writing as healing	Process of reflecting, expressive writing, storytelling, and listening perceived as beneficial.	1. Writing invites working with difficult emotions.
		2. Writing invites reflection and healing.
		3. Reading aloud invites witnessing.
Co-creating layers of connection	Intimate environment fosters emotional support, conviviality, and mutuality.	1. Feeling welcomed
		2. Feeling safe
		3. Feeling connected
Preferring face-to-face contact	In-person sharing valued over virtual contact. Structural and technical challenges to online sharing.	1. Online platform challenges
		2. Preferring face-to-face

support for health care providers. For example, participants described challenges in finding social support beyond their coworkers: “It’s not dinner conversation generally speaking [death] or even with close friends who haven’t had that experience. It’s hard to find common ground in that.” (3) For younger health care professionals, the challenge is compounded: “None of my friends have experiences with death, so it’s not really something—I don’t go around sharing my stories of death with friends” (1) and “It’s not something that you can talk about with everybody” (4).

Some work environments such as palliative care are known for leading the way in caregiver support; participants working in specialized palliative units seemed to have more options; however, perceptions of support provided on other units varied. Some participants spoke of debriefing sessions that are offered but are aimed toward problem solving or learning from mistakes. Although these efforts were applauded, they were also described as limited because of time constraints or their instrumental focus: “Sometimes in our busy days it’s hard to have room for that pause...for the depth of this kind of debriefing” (5). In contrast, the DS evening took place outside work and was less goal oriented: “What remained for me [about the dinner] is that it is a place to talk about these sorts of things and...be in that supportive space” (2). The DS evenings were seen to differ from current debriefing sessions primarily in the goals of sharing rather than fixing: “The story was received and not commented on, argued about, [or] reinterpreted” (6). Overall, participants believed that their institutions do not yet have a culture of care for staff; the onus for self-care remains an individual responsibility. The remaining themes illustrate how participants perceived the DS evening as a collective, community approach to self-care with strengths and limitations.

Storytelling and Writing as Healing

Participants shared how writing and recalling stories that linger evoked emotions that were often intense and hidden. As a social worker noted:

It is interesting how these emotions just build and create something, and writing was a way of expressing these emotions that were kind of sitting there... So yea, it was a very powerful process I would say...making sense of things. [And later] As I was writing it I was, you know, at one time I could feel tearful and another time like a big smile on my face. I was very engaged with writing it. (5)

Although not always easy, the writing process of re-visiting the difficult experience was seen as worthwhile: “I will never forget telling the child that the patient and baby died” (12) and “So that was a bit of a challenge maybe, reliving it, but challenges can be beneficial” (10). The

opportunity to share the emotional residue accrued through caregiving was seen as important and beneficial:

...being able to express all of the sadness and the ethical distress people experience, and [the] lack of support maybe at times...just the nature of the suffering that we are present to and experience. So I think it’s valuable to express that in sort of a supportive environment. And I did feel it was supportive. (3)

The stories addressed a range of topics including moments of helplessness, advocating for families against perceived harms, moments of intimacy and love, feeling abandoned by the organization, learning to live with mistakes, and honoring caregiving as a service. Generating stories from past experiences assisted their meaning-making process: “It helped me reflect [on the experience], I don’t know, I think people remember things better as stories...it’s such a personal emotional thing...” (1) and “Every time I write about a patient I feel in some way, that I’m honoring them; nobody really wants to be forgotten” (7).

Most participants did not know others in the group and expressed some anxiety about attending. The host emailed guests before the evening providing reassuring information and encouragement. The evening was also designed to provide opportunities for “ice breakers,” getting to know one another over dinner, and building trust and comfort. Then, after the meal, participants moved into the living room and each person, in turn, read his/her story, followed by an open-ended discussion led by the host facilitator. The experience of storytelling aloud is reflected by one participant as “being witnessed and validated” (2).

The positive impact of listening and being listened to was expressed in a variety of ways: “...just being able to be, to share and be heard. Something that’s close to your heart and being able to have other people there—” (8). In summary, participants identified benefits of writing that included working through difficult emotions when reliving their experience and reflecting deeply to narrate effectively. Participants expressed the positive impact of both voicing their story aloud and being witnessed through the group’s full attention. Some participants worried about the quality of their written stories, but such concerns were not barriers to participating.

Co-creating Layers of Connection

The next theme addresses the importance of mutuality in co-creating an environment that was welcoming and safe and that fostered genuine connections among participants. In particular, the importance of the home setting and careful attention to the menu and nutritious food were key: “It was a really cozy environment, we were welcomed in. I think having appetizers and snacks helped everyone to ease in,” (1) and there was a feeling of “being cared for” (7).

Being in somebody's home, I felt this is a good way to get to know people on a different level because it's a friendly atmosphere... And then in the living room the way she had placed the furniture was interesting, very close together so that there was not much distance between people. I thought that was very clever. (7)

Participants remarked on the nurturing environment and the ways their host helped create a space of ease and relaxation. In particular, the provision of a home-cooked meal was literally and metaphorically nourishing. As one social worker shared:

For me, feeding people was a big plus. You know—breaking bread comes to mind—I'm not a religious person but the breaking of bread creates a sense of community, creates a sense of shared experience. I don't know if it's the feeding of people together, because that had a huge impact on me. (9)

Participants acknowledged the importance of a skilled facilitator in creating a sense of safety. As one person shared, "It takes a good facilitator—I think, to run something like this, to make people feel comfortable and then want to share and open, and read their story" (3). As noted, most participants did not know one another and yet the evening was described as "a very intimate environment" (9). Safety was key to allowing deeper levels of sharing: "Everyone was quite willing to be vulnerable in their sharing and so I guess I felt comfortable" (9), or as one person shared about feeling anxious and how this was eased:

I liked how [the facilitator] at the beginning made everybody say they were sorry right away [in unison], because she knew that as soon as people started reading their stories they would start making excuses about, "oh, it's not a very good story, I'm not a very good writer, I'm not a very good reader," lah-lah-lah. So nobody was allowed to say that, which was good, it meant that everybody was feeling the same as I was feeling. You know, a bit nervous. (10)

As another participant explained, "We were listening on various levels—I was surprised by the depth of vulnerability and sharing that people opened into" (11), and "It was very important to have other people listening to me, and at the same level I was trying to show them that I [was] listening" (12). A sense of mutual disclosure and trust was generated and fostered skillfully by the host facilitator.

Preferring Face-to-Face Contact

Participants were also invited to log into an online forum and continue discussing their stories or anything arising from the dinner. These online forums were voluntary and accessible

for 1 month after the dinner using a secure portal on the hospice website. Only a few participants used the virtual site. During follow-up interviews, participants expressed an overall disinterest in sharing virtually. Some identified confusion and frustration when accessing the site: "I was a little uncertain about what I was supposed to do" (9), and "I found it a little hard to maneuver around; I had some problems getting in. And then I couldn't find people's blogs. I didn't think it was very user-friendly" (7). One participant found the postreflection helpful: "It did help me to think through some of the process experiences—the actual (event), how was this for me?" (1). Overall, the option for sharing virtually was not appealing to most participants.

Professional Impact and Recommendations

When asked how the DS experience might impact their professional work and what limitations or suggestions they might offer, participants acknowledged the power of sharing together and some participants wondered whether the dinners could be offered in a series, rather than a single event. One participant voiced, "If it's just one evening like that you're just kind of left there" (3). Although this was not a dominant view, the comment offers a direction for future studies and is addressed later. Another participant acknowledged the power of the environment created yet wondered about the pragmatics of cooking dinners. She questioned whether the embedded elements of storytelling and sharing could be provided in a less elaborate way.

Could you do it in a lounge area where you could have tea and coffee and biscuits and cheese and people could come in at a certain time every week and they would know there would be a leader there or a host and they would be able to have these conversations? And I think yes, you could absolutely do that. (4)

Participants reiterated the importance of having opportunities to share genuinely about their caregiving experiences at work and the need to process difficult situations. A counselor recalls a coworker who had been gathering together different coworkers on her unit, "...every week, having dinner and stories. Not quite the same format...and how helpful that was" (12).

One participant questioned the usefulness of the term *self-care* itself because of the community-enhancing aspect of the dinner event, whereas she associated "self-care" with individual activities: "I wouldn't call it self-care...if I was gonna do self-care I would go to my yoga class or I would meditate.... So for me, all the self-care that I do is internal" (6). Participants expressed an attitudinal shift of appreciation for their colleagues and the work they do. As one nurse said, "...one of the big impacts it had on me was just recognizing what we do and it's

remarkable...and yet it's never mentioned, you know, on a day-to-day basis" (13).

DISCUSSION

The use of creative nonfiction storytelling as a tool for self-care in the context of health care is not well described in the literature. Findings from this study suggest that the DS initiative is perceived as helpful, assisting in meaning-making and providing a venue for healing that combines individual writing, reflection, and group support through storytelling and listening. Understanding why the DS event is perceived as helpful will be considered through the conceptual lens of social support and then combined with what is known about reflective writing as therapeutic.

Social support has been extensively researched identifying its positive relationship with health and well-being.²⁴ Findings from this study align with more current notions of social support such as those of Schlecker and Fleisher,²⁵ who no longer focus on the provision of services and goods to needy recipients but more broadly recognize how people benefit from mutuality and a sense of existential sharing.²⁶ Similarly, Thoits²⁷ identifies two types of social support: emotional support and active coping assistance. One difference between DS as a model of self-care and debriefing or critical incident review is that they constitute different types of social support. The DS event elicits emotional support of empathy, listening, and role modeling, and participants are discouraged from actively problem-solving or interrupting the storytelling while being encouraged to listen and witness. This differs from active coping assistance such as formal debriefing or critical incident discussions. Although both types of social support are provided by peers or other health care professionals, the former kind of support (such as a DS model) is thought to be more effective in alleviating the impacts of emotional stressors.²⁷ Findings from this study suggest that the DS event resonates with Schlecker and Fleisher's^{25(p12)} model where "existential sharing...and a longing for conviviality" are aspects of feeling supported. Valuing feelings of safety and hospitality was highlighted by participants at each dinner event. This seems to underpin the importance of mutuality, vulnerability, and deep levels of sharing as beneficial outcomes of the dinner event.

Stories that lingered for participants often had a strong emotional content. Because literature on self-care often focuses on either individual practices²⁸ or active coping assistance,²⁷ managers and organizations fall short in providing opportunities for adequate emotional and deeper levels of engagement. Our results suggest that health care providers crave the sense of connection with colleagues that goes beyond individual relationships. Such connection helps to give meaning to the suffering professional caregivers experience in their work.

The study finding that writing and storytelling were healing adds to a growing body of evidence about creative nonfiction and expressive writing.^{14,29} Findings show that writing about lingering caregiving experiences afforded opportunities to relive sometimes difficult situations and to effectively renarrate the experience so that it could be shared in a group setting. This supports findings of storytelling as one possible avenue for professional identity development,¹⁵ especially when personal and professional integrity are challenged as a result of suffering experiences. Findings also emphasize the centrality of co-creating trust, safety, and mutuality and the importance of a skilled facilitator in generating effective storytelling spaces.

Implications point to the ongoing lack of a culture of care for caregivers in health care settings; fostering this culture is a work in progress that needs attention. Our findings challenge the implicit understanding that nurses and other professionals should be able to protect themselves from deep emotions and somehow be impervious to their own suffering. Participants' narratives reinforce the need for additional caregiver supports that go beyond individual self-care to include a social context where sharing and listening to stories can foster a community of care. There is a call to expand venues for caregiver support where nurses can not only tell their stories but also tell stories differently.³⁰

Longo³¹ found in her study that nurses are better equipped to be caring when they are cared for themselves. She notes that "willingness to listen," "acknowledg[ing] an individual's struggle," and "coming to know and appreciate each other"^{31(p14)} on the part of other nurses is a vital component of caring for one another. Findings from this study show that storytelling in a safe, informal environment is one way to support health care providers who encounter the inevitable struggles in caring for people at the end of life. Similarly, concern about burnout among health care providers is well founded because of its negative impact on patients and the workers themselves. A pilot study that focused on tackling burnout in nurses³² found that it is often brought about by the emotional demands of witnessing patients' suffering, which in turn causes the health care professional to suffer. Research suggests that this suffering is commonly endured in silence and organizational cultures and environments rarely offer resources and strategies for professionals to share their feelings in a healthy way.³²

Although further study is required, the potential of combining individual self-care through creative nonfiction writing with emotional support in a social context offers promise. Within fast-paced, efficiency-oriented health care settings, a culture of efficiency seems to take precedence over a culture of care for caregivers. Further inquiry into whether attitudes and practices of "conviviality" such as sharing a meal in a comfortable home setting could shift

the workplace culture of care is needed. Although most participants did not find the online platform helpful for sharing and storytelling, further inquiry into potential venues, formats, and frequency of dinner events is needed. Would a setting within the workplace and with less attention to environment and food render similar experiences of benefit?

Trustworthiness of the Study

Trustworthiness of the study was maintained using a detailed audit trail recording all analysis decisions, tracking theoretical and writing process memos. This enabled the team to trace our research decisions and reflect on whether these decisions were reasonable. Writing reflective memos, discussing issues of analysis during intensive analysis sessions, and listening to and questioning our assumptions contributed to the critical reflexivity and integrity of this project. Limitations to consider include a predominance of female participants (all but two) that may influence the kind of experiences shared. In addition, we were not able to distinguish which elements of the DS (writing process, social environment and meal, skilled hosting and facilitation, or the reading aloud and empathic listening) are responsible for the expressed benefits.

Conclusion

Storytelling is a social process that offers potential as a community approach to support nurses and other health care providers. Fostering a culture of care among and between caregivers requires leaders to support initiatives that go beyond individual self-care practice and build community. Findings from this study add to knowledge about the therapeutic benefits of writing and telling stories,^{20,32} including enriched meaning-making, emotional conveyance, and therapeutic connections between storytellers and listeners.

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