Storytelling Intervention for Patients With Cancer: Part 1—Development and Implementation

Bronwynne C. Evans, PhD, RN, FNGNA, ANEF,
Neva L. Crogan, PhD, APRN, BC, GNP, FNGNA, and Robert Bendel, PhD

Purpose/Objectives: To develop a nurse-led storytelling intervention for patients with cancer and implement the intervention using trained oncology nurses.

Design: Descriptive pilot project using qualitative methods to assess implementation of an intervention tool kit, with investigators blinded to control and intervention group membership.

Setting: Local regional medical center in the Pacific Northwest region of the United States.

Sample: A convenience sample of 11 patients with various cancer diagnoses was used for tool kit generation. Intervention and control groups were then formed and used to study tool kit implementation.

Methods: Participant exit interviews and facilitator debriefing questionnaires assessed the ability of a nurse facilitator to use a group storytelling intervention tool kit. Data from control and intervention groups were analyzed and compared with qualitative procedures.

Main Research Variables: A nurse-led storytelling intervention.

Findings: Analysis of interviews and questionnaires revealed implementation of storytelling tool kit principles and differences between storytelling and control groups in three patterns: finding a soft place to fall, understanding the cancer experience, and figuring out how (if) to get through it.

Conclusions: Techniques contained in the tool kit were implemented and deemed clinically useful by oncology nurses.

Implications for Nursing: Given the small testing groups, pilot project results must be interpreted with caution, but with additional research and instructional development, the tool kit could be useful to nurses in a variety of settings and locales.

Key Points . . .

➤ Inexpensive, holistic, noninvasive psychosocial nursing interventions are needed for patients with cancer.

➤ Nurses welcome additional therapeutic modalities that can decrease client suffering.

➤ Stories help patients find meaning in their daily lives, suffering, and impending deaths.

A Nurse-Led Storytelling Intervention

Storytelling is an inexpensive psychosocial nursing intervention with minimal patient risk that may be effective for patients with chronic illness (Clarke et al., 2003; Utley, 1999). In the current study, the intervention was based on experiences in teaching caring to nursing students through story (Severtsen & Evans, 2000), literature that examines the worth of story in nursing practice (Carson & Fairbairn, 2002), the importance of behavioral and psychosocial interventions on quality of life (Burish, 2000; Spiegel, Stroud, & Fyfe, 1998; Ten Kroode, 1998), and use of stories as a vehicle to understand experiences (Cohen, Haberman, & Steeves, 1994; Cohen, Kahn, & Steeves, 1998; Kahn & Steeves, 1988, 1994, 1995; Steeves, 1992, 1996).

Liehr and Smith (2000) and Smith and Liehr (1999, 2003) proposed a middle-range theory in which story can be used to guide nursing practice. Many of the constructs in their theory, such as the caring-healing context of story and bringing the nurse's own humanity to the storytelling moment, defined this process. Other constructs were not as congruent with the principles, including the intervention of allowing the story to come forth at the storyteller's own pace. Rather than asking

N urse educators have long used stories to transform thinking about teaching (Diekelmann, 1991) and to teach students about human experiences, such as suffering (Boykin & Schoenhofer, 1991; Kirkpatrick, Ford, & Castelloe, 1997). Stories also have been proposed as a foundation for nursing practice (Clarke, Hanson, & Ross, 2003; Leight, 2002; Moules & Streitberger, 1997; Sandelowski, 1994; Smith & Liehr, 1999). Even if they are tragic, stories facilitate understanding, encourage growth in the face of crisis, and provide direction for people's lives. Remembering stories, assigning meaning to them, and reshaping them helps people find meaning in their lives (Sandelowski). Nurses who use caring moments to acknowledge and validate patients' realities are entrusted with stories that immerse them in the tragedy and passions of their patients' lives (Moules & Streitberger). This article will report on a series of such caring moments provided by the development of a nurse-led storytelling intervention for patients with cancer and the implementation of the intervention by oncology nurses.

Bronwynne C. Evans, PhD, RN, FNGNA, ANEF, is an associate professor in the College of Nursing and Healthcare Innovation at Arizona State University in Phoenix; Neva L. Crogan, PhD, APRN, BC, GNP, FNGNA, is an associate professor in the College of Nursing at the University of Arizona in Tucson; and Robert Bendel, PhD, is a research professor and statistician in the College of Nursing at Washington State University in Spokane.

about thoughts or feelings, or presenting the nurse's impressions for the client to "elaborate, refute, or accept" (Liehr & Smith, p. 15), the nurse facilitator let the story come to her, to be told and retold as the group made meaning of the experience, not the nurse.

The conceptual framework for development and implementation of the intervention was Watson's (1988) Theory of Human Caring, particularly her work on intentionality and caring-healing consciousness (Watson, 2002). Watson identified a caring moment, such as those used in the current study's nurse-led intervention, as a coming together of nurse and patient in which an intimate, spiritual, transpersonal connection opens possibilities for healing. Such a connection preserves human dignity, is characterized by an authentic presencing on the part of the nurse, and supports human transcendence in the face of illness, disease, suffering, vulnerability, and death. Although Watson's body of work on theoretical stance provides a window through which to view such experiences, the theory itself is a belief about what nurses accomplish and may not be shared by the patients. With this in mind, Watson provides the framework for assessment of the capability of practicing oncology nurses, trained in use of storytelling, to successfully implement the intervention.

Development of the Storytelling Intervention

Phase I: Examining the Potential for Storytelling as a Nurse-Led Intervention

Round 1: A group consisting of six outpatients diagnosed with cancer took part in an initial 10-week development project that examined principles derived from a storytelling class in which caring was taught to nursing students through story (Severtsen & Evans, 2000) as a potential basis for a nurse-led intervention. Group participants learned to listen nonjudgmentally to one another's stories and to formulate and tell their own stories. Understanding the cancer experience through the use of stories was discussed as opportunities presented themselves during the sessions. Participants examined control issues, desires in the face of their disease, relationships with others, and the alteration of their maps and destinations for life because of cancer. Traditional group process techniques, such as gatekeeping and probing for coping skills, were eschewed in favor of creating a safe place where stories could tumble out as participants needed to share them; no one searched for stories that were not ready to be told (Errante, 2000). Group rules emerged, such as tacit permission for a member to "have their night" when severely distressed, understanding that if others needed concentrated group attention in the future, they would receive it.

According to Watson (1988, 2002), nurses can potentiate healing for their clients and their relationships, help them to find meaning in and transform their suffering, and accept the life journey, including death. Five measures associated with these outcome variables were used with a convenience sample of 11 patients with various cancer diagnoses randomly assigned to an intervention (n = 6) and a control group (n = 5) to assess whether the techniques devised for storytelling affected participants' abilities to find meaning in, interpret, and reinterpret their illness experience. Two nurse educators who had developed and used these techniques in the storytelling class helped facilitate the study. The five instruments were the **Index of Clinical Stress** (Abell, 1991) to measure the magnitude of the participants' subjective stress levels; **Cantril's Ladder** (Kilpatrick & Cantril, 1960), a global indicator of coping with life; the **McGill Pain Questionnaire** (Melzack, 1975) to measure complex qualitative pain experiences; the **Satisfaction With Life Scale** (Diener, Emmons, Larsen, & Griffin, 1985), which measures an individual's own judgment of his or her quality of life; and the **Brief Depression Rating Scale** (Kellner, 1986), used to measure depression by clinical observation.

In this study, the control group was formed to foster participants' coping abilities and provide social support and information on cancer treatment. A social worker employed by the medical center was the control group's facilitator. She avoided storytelling (except for random, natural occurrences) and self-disclosure; and used traditional group process techniques such as keeping the group on track with the session's agenda, preventing domination of the session by one person, and probing or analyzing participants' coping strategies.

The five measures were administered to the two groups at the beginning of the 10-week round. All but two control group members dropped out, making a cross-group comparison impossible. An exit interview was added to document qualitative data that could not be captured by the five study instruments.

Round 2: At the end of the first round, the remaining two individuals from the control group were folded into the storytelling group so that all could receive the intervention. The group continued for an additional 10 weeks. At the end of the 10 weeks, instruments and exit interviews were used to evaluate the meaning of the group for each participant.

Phase II: Generation of the Tool Kit

Following phase I, storytelling techniques were reexamined in light of newly published journal articles on storytelling. Storytelling principles gleaned from Frank (1997) and the storytelling class were compared and contrasted with traditional group process principles. Convergence and divergence between the two approaches were identified, and a written, formalized tool kit was created for the next exploratory step in the adaptation of the storytelling class techniques. The variable of nurse-led storytelling was defined as a narrative-based method of forming and maintaining a safe, nonhierarchical therapeutic community in which stories are elicited, told, and listened to nonjudgmentally in an effort to understand the cancer experience. Components of the tool kit included (a) guidelines for the formation of such a community where self-disclosure was encouraged by caring behaviors of participants and the facilitator, (b) journal references to theoretical principles for storytelling, (c) specific strategies for presenting the concept of storytelling to clients, (d) techniques for using stories to understand the illness experience, (e) ways to focus on the personal story of the illness rather than the medical story of signs and symptoms of the disease, and (f) advice for witnessing (being emotionally present for) and formulating stories about suffering and growth associated with a cancer diagnosis. Techniques helped participants consider issues of control over their disease, desires about eventual outcomes, and alterations in relationships with others, using storytelling as a health promotion and healing technique (Koithan, 1994; Sandelowski, 1994).

Training Nurse Facilitators

The tool kit generated in phase II was used to hire and train two nurse facilitators for implementation of the nurse-led storytelling intervention with a group of patients with cancer. An eight-hour training session was provided for the two practicing oncology nurses to discuss and practice the principles and guidelines (one was trained as a substitute for the primary facilitator in case of illness or other emergency).

Methods

Sample and Setting

To determine whether the nurses were able to effectively implement the tool kit and create a climate for interpreting or reinterpreting the cancer experience that differed from the climate found in groups using traditional group process, a convenience sample of 10 patients with cancer (nine women, one man; age range = 48–74 years) was recruited through a local regional medical center in the Pacific Northwest region of the United States. No ethnic group, gender, cancer type, time of diagnosis, or status of prior or current treatment was excluded. Participants were under the care of a physician, spoke fluent English, and were willing to share information in a group. Of the 10 participants, one woman withdrew from the control group prior to the first session because of a family illness and two withdrew from the storytelling group after the first session because of personal reasons.

Following approval of the study by both the university and medical center institutional review boards and after informed consent, participants were randomly assigned to either the storytelling group facilitated by a nurse or the control group facilitated by a social worker. Although some negative effects of self-help groups have been reported (Caserta & Lund, 1993), extensive discussions with medical center researchers and an oncologist specializing in psychosocial care determined that the potential for negative effects in this case was small. A 12-week session (as opposed to eight weeks in Caserta and Lund's study) was planned to allow participants with high self-expression and social skills to establish relationships with other group members and to work through any depression prior to the study's completion. Participants with fewer interpersonal skills would experience social support throughout the intervention. In the event that any adverse effects occurred, the participant would be referred to another support group or a counselor, and a report would be made to the institutional review boards of the medical center and the university that had approved the project.

Procedures

In the storytelling group, a nurse facilitator guided participants through 12 1.5-hour sessions in which the participants selected content and process based on the stories they chose to share. Although any support group for patients with cancer provides an opportunity to share stories about illness and therapy, the spontaneous, random, unsystematic storytelling in the control group did not profit from the deliberate guidance in storytelling used in the intervention group. The random storytelling in the control group was seen as a po-tential threat to accurate evaluation of the intervention and was monitored closely; nurse and social worker facilitators independently completed debriefing questionnaires following each session. The questionnaires were intended to differentiate the occurrence and use of story in the groups through descriptions of group process, specific facilitator techniques, group response, and level of interaction between participants and facilitators. The facilitators were instructed not to discuss their experiences with one another during the project, and group participants did not know whether they belonged to the storytelling or control group.

At the end of 12 weeks, an unstructured, audiotaped, 20- to 30-minute exit interview with each participant was conducted. The meaning of the group for each participant was explored through the question, "What has the experience of being in the group been like for you?" The interviewer's role was merely to indicate nonverbal interest in the story (e.g., through gestures, expressions) and to use short probes to encourage reflection.

Data Analysis

Exit interviews and facilitator debriefing questionnaires were used to assess the ability of the nurse facilitator to effectively implement the storytelling techniques and differentiate the storytelling group from the control group. To control for bias, a research assistant removed information from verbatim transcripts of exit interviews that might identify which group each participant attended (Vogt, 1998). A project investigator then divided the interview transcripts into coherent sections, with each section containing one construct (e.g., coping strategies), and forwarded the transcriptions to a second investigator. Using procedures set forth by Miles and Huberman (1994) and working independently, the two investigators read each interview for context and meaning, identified themes (recurring topics or ideas) in each section, and recorded them on worksheets. Those thematic analyses were compared, with a 95% interrater agreement being achieved on substantive identification of themes and theme content (variation in wording permitted). Membership of each group was then revealed.

Questionnaires were subjected to the same blinding process as the interviews. Group membership was again revealed after identification of themes and theme content. Themes then were examined for evidence of implementation of storytelling tool kit techniques and differentiation of storytelling (indicated by use of the word *story* or specific references to the components of the tool kit) between the storytelling and control groups.

Using a data grid as a means of reducing and comparing data across cases, the two investigators clustered the interview and questionnaire themes into patterns or categories that captured the essence of all themes within that category (Miles & Huberman, 1994; Wise, Plowfield, Kahn, & Steeves, 1992). Those patterns were examined using Watson's (2002) framework of Intentional Transpersonal Caring-Healing that emphasizes connectedness, subjective meaning, and shared spiritual dimensions between the nurse and client. In this framework, the nurse uses intentionality (an action-oriented awareness or consciousness) to potentiate the client's caring-healing energy and create a safe, sacred, authentic space, replete with commitment and loving attention.

Findings and Discussion

Evidence in the interviews and debriefing questionnaires indicated that the nurse facilitator was able to implement the storytelling tool kit. That evidence emerged from the data in the form of three patterns. The three patterns also provided insight for distinguishing the storytelling group from the control group using Watson's (2002) description of the caring moment, where the tasks of humanity and nursing intersect. The patterns were Finding a Soft Place to Fall, in which the individual finds meaning in life while reawakening compassion and caring on the spiritual journey; Understanding the Cancer Experience, in which the individual understands and transforms suffering, deepening understanding and acceptance of the life cycle and death; and Figuring Out How (If) to Get Through It: Coping and Not Coping, in which the individual heals relationships with self and others (see Table 1).

Although the storytelling group was comprised of only three participants who completed the 12-week session (compared to four participants in the control group), the storytelling group produced a wider variety of themes relating to Watson's (2002) tasks under the Finding a Soft Place to Fall and Understanding the Cancer Experience patterns. Figuring Out How (If) to Get Through It was subdivided into coping and not coping themes. Although both groups could describe coping using internal mechanisms (i.e., coping strategies focused on intrapersonal resources) and external mechanisms (i.e., coping strategies focused on outside resources), not coping themes displayed some differences. For example, when asked to describe what not coping looks like, the storytelling group listed a wider variety of internal mechanisms that were characteristic of failure to cope than did the control group. The only external mechanism indicative of not coping was identified by the control group: "running to the doctor if you feel something different and you think it might be cancer again." That finding may indicate increased insight in the storytelling group as to the differences between effective and ineffective coping (see Table 2).

The storytelling group believed that they could share their feelings and feel accepted and secure, despite low energy levels.

Table 1. Total Number of Group Themes Identified in Patterns

Pattern	Storytelling	Control
Finding a Soft Place to Fall	8	6
Understanding the Cancer Experience	7	3
Figuring Out How (If) to Get Through It		
• Internal mechanisms[a]		
– Coping	4	5
– Not coping	5	2
• External mechanisms[b]		
– Coping	4	3
– Not coping	–	1
• Total		
– Coping	8	8
– Not coping	5	3

[a] Internal mechanisms: coping strategies focused on intrapersonal resources

[b] External mechanisms: coping strategies focused on outside resources

The group also articulated a broader range of themes, indicating understanding of the cancer experience, and described more fully what not coping looked like. That may indicate that they were better acquainted with, or had more insight into, not coping compared to the control group. The control group articulated the only feelings of uncertainty about expectations of the group experience; although they were glad to blend into the crowd, they felt they could be truthful and still be accepted and supported.

Finding a Soft Place to Fall

Storytelling group: The tool kit required self-disclosure by the nurse facilitator and sharing personal information with participants through stories as a means of role-modeling trust. In terms of Watson's (2003) framework, the facilitator suspended her usual role as an authority figure to become vulnerable and acknowledge her own humanity. Such self-disclosure on the part of the nurse facilitator helped one participant feel less vulnerable and more understood, rather than analyzed. "It was like my own personal therapy session, only better because you shared your experience, too." Another was thankful that she had found a place to openly discuss her fears about her cancer diagnosis; she was not allowed to do so at home because her husband strictly believed in positive thinking.

The facilitator was instructed to allow stories to come forth as group members chose to tell them, instead of pursuing the stories she wanted them to tell. She was cautioned that revisiting past experiences could evoke pain and that making private memories public may not be easy. Based on the interviews and questionnaires, the nurse facilitator was able to let participants "choose what they wished to remember and tell . . . and participate in negotiating the context of remembering" (Errante, 2000, p. 19). She also was instructed to avoid gatekeeping that could shut off stories as they began to surface. She countered this by allowing members to each "have their night" if they were severely stressed, emphasizing that the same courtesy would be extended to others as needed.

Those strategies were reflected in two outliers defined by Miles and Huberman (1994) as exceptions to the rest of the qualitative data. Such exceptions alert the researcher to guard against bias and help to refine a construct or test generalities that seem to emerge from the data. Although others felt safe in the group, one participant shared some private information despite considering herself "not the type of person to share personal feelings." She reported that this information was later revisited in a joking manner within the group. "I didn't feel I had the freedom to say that I didn't appreciate that . . . but it showed me that you have to still be very careful." The participant also expressed conflicting thoughts about the way the storytelling group was run.

> Where one person monopolizes the group . . . whether that person should have been controlled or whether it was good because the person knew they'd be helped. I still haven't quite figured that out because I saw the person change considerably from when they first started the group.

The evidence underscores the importance of creating a Soft Place to Fall and possible need for additional facilitator training and participant teaching. The participants' conflicting thoughts, however, acknowledged the deliberate lack of gatekeeping and questioned whether it was helpful to other

Table 2. Themes and Patterns Derived From Interviews and Debriefing Questionnaires

Pattern	Storytelling Group Themes	Control Group Themes	Storytelling and Control Group Themes
Finding a Soft Place to Fall	Experimenting with sharing feelings Saying things you have said to no one else Trusting Feeling balanced and secure Having enough energy	Blending into the crowd Feeling uncertain about what to expect Being able to be truthful	Not having to be strong Being supported and accepted Looking forward to benefits
Understanding the Cancer Experience	Realizing that you might live Learning to deal with loss, bouncing back Understanding that others burn out Understanding thoughts about death Understanding that everyone has a title Understanding there is no failure on your part	Learning to talk to new people about cancer experience Realizing cancer affects everything	Talking to others who share the cancer experience
Figuring Out How (If) to Get Through It • Coping	Praying Taking care of your health Not abusing self Not abusing others	Not thinking about cancer Getting on with life Worrying only if the cancer comes back Dealing day by day	Thinking positively Helping others Attending group Gaining support from family and friends
• Not coping	Despairing Being stuck in loneliness Giving up and dying Being buried in depression Being miserable	Being consumed by disease Wondering if the cancer will come back Running to the doctor's office	No themes identified

group members. The statements of exception were useful during analysis because they provided evidence that the nurse facilitator had avoided gatekeeping as instructed, as well as evidence of a possible therapeutic outcome for the participant undergoing change. Also indicated was a beginning acceptance by the woman who provided the outlier statements that, when the "monopolizer" worked to heal herself in the context of the group, she "contributed to the healing of the whole" (Watson, 2003, p. 201).

Silences in the group were documented as natural and comfortable. Group members appeared to reflect on or contemplate stories just disclosed. This is typical of transpersonal caring activities (Watson, 2003).

Control group: Self-disclosure by the leader is somewhat unusual in traditional group process when the leader usually is focused on keeping the group on track with the agenda, gatekeeping to prevent monopolizing of the session by one person, or analyzing and probing coping strategies. The social worker facilitator, however, unexpectedly used self-disclosure to encourage group members to reveal personal information, paralleling the storytelling group facilitator's technique.

Control group activities emphasized education with a guest speaker and distribution of printed materials. Debriefing questionnaires showed that participants continued to look strongly to the facilitator for guidance, despite her efforts to shift the leadership to group members. Silences occurred on several occasions and were described as peaceful but uncomfortable. However, participants expressed their appreciation for the caring they found in the group and consistently treated one of the quieter women with affection, reflecting that they experienced her quietness as "patience and strength."

Understanding the Cancer Experience

Storytelling group: The nurse facilitator was able to avoid judging, analyzing, and extracting data from the stories and seemed to accept them as whole and true to the teller, as instructed (Watson, 2003). She avoided probing discussions on coping strategies but worked to get in touch with participants through an interpersonal bridge created, in part, by her own self-disclosure (Errante, 2000; Watson, 2003). Those strategies were aimed at producing "virtually shared experiences" (Errante, p. 24) that allowed group members to vicariously enter the storytellers' realities and work toward shared meaning (Watson, 2003).

To suspend role and status (Watson, 2003), the nurse facilitator initially informed the group that she considered them to be the experts on the cancer journey. Subsequently, she was treated more like a group member than as a leader, with participants telling and retelling their stories to one another as they worked to make meaning from the cancer experience. Frequent retelling may have occurred because stories allow people to forget and reinvent certain aspects of their pasts, making them more acceptable in current circumstances (Errante, 2000). The stories often need to be reexplored for meaning in light of what participants now know. Revised versions then are used to validate identities and suffering, for both the participant and the group. Such validation was appreciated by one woman who said, "The group helped me see that the things that were happening weren't because of a failure on my part or something I had done wrong, or not done."

Other evidence of implementation of the storytelling tool kit was noted in participants' visible and frequent use of

storytelling as they sought to discover meaning (Leight, 2002). Their stories acknowledged that the cancer diagnosis requires the creation of a new map for their lives; that relationships with others are irretrievably altered; that bearing witness to the cancer story, despite its telling and retelling, is a healing gift (Watson, 2003); and that the medical narrative, chosen initially by both groups in this project as a way for members to tell their stories in an oft-rehearsed, socially sanctioned format, cannot fully express the illness experience. The medical narrative, the short-hand technical language universally used by healthcare providers, furnishes an efficient way for patients to communicate to others about cancer. Unfortunately, this narrative may fail to consider how cancer is experienced or to honor the differences in healing journeys (Watson, 2003). The nurse facilitator was cautioned about reliance on such narratives and was able to guide participants in telling their own personal stories of illnesses.

Attention to individual patient suffering was provided by exploration of the stories and not the clinical stories of the disease process (Emblen & Pesut, 2001). As the group worked together to understand their suffering, one woman was "faced with the fact that I might live, then what?" despite many family members dying of the disease. That realization changed her suffering and she "started dancing again. I gave it up for three years!" Another woman referred to an essay by Kingsley (2001) and likened her cancer diagnosis to a trip to Italy (her metaphor for health and wellness). She talked about her excited anticipation and preparations for the trip; but when the plane landed, she was in Holland. She suffered: She was lost, cold, and unable to communicate with others but she did the best she could on the unanticipated journey. Others entered into her metaphor for suffering, saying, "It's Holland, and I don't like tulips!" "I'm stuck and I can't read the map," and "I'd rather be in Italy with my friends!" They told stories about the loss of familiar, beloved things; shared their sense of vulnerability; and expressed resentment at lost companionship. But then one said, "Well, I'm going to Italy as well," which led to stories about self-pity and how counterproductive it was to the daily business of living.

Control group: The aim of the control group was to foster participants' coping abilities and to provide social support and information on cancer treatment. Participants occasionally told stories in response to questions about their health (Sandelowski, 1994), but they usually used the medical narrative. Unlike the nurse facilitator in the storytelling group, who avoided breaking stories apart to analyze them, the social worker facilitator used traditional group process techniques such as extracting and analyzing aspects from each participant's contribution for discussion. However, participants expressed relief at finding others who understood the fears and pain of cancer diagnosis and treatment (perhaps a precursor to recognizing the importance of bearing witness to others' suffering, if guidance had been available), as well as an opportunity to gain information about the disease. Patients sometimes mentioned their own personal experiences with cancer, although a difference between their stories and the medical narrative was not recognized. One such occurrence focused on hope, and the participants offered their own symbols for hope, expressed hope for effective treatment, and asked that a candle be lit "to give us spirit."

Figuring Out How (If) to Get Through It: Coping and Not Coping

Storytelling group: Group members discussed bearing witness to each other's stories with the guidance of the nurse facilitator, recognizing that it was not about fixing the issue or even having something to say, but just being with people (Quinn, Smith, Ritenbaugh, Swanson, & Watson, 2003), acknowledging who they were, and reminding them that their disease did not define or tarnish them. They talked about life, hope, and fear in the context of their personal narratives of the cancer experience: "custody of my grandchild who needed the normal, healthy parent in me," "watching a plant grow under my nurturing care," "living what is today," "fear of suffering, not of dying," and "someone bearing witness to your life." Two women, however, had difficulty determining how to proceed; one felt stuck in a victim role and could not see past that (although she held out hope for the future), and another reported that her skin burned from radiation and that she had feelings of depression.

Control group: Group members tearfully discussed getting through the cancer journey with strengths they had not known they possessed prior to their diagnoses and were pleased with their ability to contribute to the project, although one woman found it difficult to live with uncertainty. They offered support to other group members undergoing crises such as divorce and scans to restage their cancer, occasionally sharing a group hug at the end of a session. One interesting dichotomy that surfaced was how they pointed out the need for understanding of each person's unique story. One participant chose to worry only if the cancer actually recurred, whereas another chose to worry about the possibility of it recurring.

Experiences of Oncology Nurses Associated With the Project

Oncology nurses from a regional medical center were recruited to participate in this project. Despite their workloads and family responsibilities, facilitators and research assistants were willing to participate. The nurses expressed interest in any technique that would ease the suffering of patients with cancer, particularly inexpensive strategies with little risk to patients. Some nurses asked to attend the sessions even though they could not be part of the project because they wanted to learn skills they could use in their own practices. The medical center provided support so that nurses could receive training, during and after the project.

The nurses involved went on to incorporate storytelling techniques into their daily practices, even if only for a moment during a hectic day, and expressed appreciation for their increased abilities to ease suffering. The nurse who took primary responsibility for facilitating the storytelling group reported a profound change in her nursing care and expressed hope that more nurses be given the opportunity to learn the techniques.

Limitations

The study included a small number of participants. A larger study would provide a greater understanding of the efficacy of storytelling groups. Also, the results of this study do not indicate whether the tool kit alone would be sufficient instruction. Perhaps the eight hours of training are vital, but a programmed instruction format could be used to present the principles and protocol in successive units followed by

self-testing. Such instruction could include a videotape or slide presentation of a teacher discussing the materials or be presented in an interactive online format. Future studies could incorporate such training for facilitators and test for achievement of educational outcomes.

Conclusions and Implications

The findings of the current study clearly are preliminary and descriptive, but they do illuminate the characteristics of each identified pattern and, as such, can be used as a basis for further investigation of the tool kit implementation process. Although limited by a small number of participants, the project provides evidence through qualitative data that oncology nurses can successfully learn and implement nontraditional techniques, such as those contained within the storytelling tool kit, to help patients with cancer find meaning in the illness experience, accept that their lives are changed by cancer, and ease their suffering. The words of the nurses themselves indicated their ability and willingness to adapt the techniques to different practice settings, as evidenced by their use at a busy oncology unit in a regional medical center.

The study raises an important question about gatekeeping in groups and the benefits and risks to individual members. Permitting a single participant to monopolize the group requires a mature understanding of group process, but it also acknowledges the need for reciprocity in relationships, allowing others to see and experience the healing of that person. The risk is that immediate needs of the remaining participants may not be met, leading to other research questions, such as: Are there patients who benefit more from a less-structured storytelling group as opposed to the more structured conventional group? How could that be determined? Is there a point in the cancer journey when one type of group might be of greater benefit?

Storytelling may be particularly helpful for emotionally vulnerable group participants who lack the energy or ability to analyze their current situations but feel better in the telling and retelling of the stories of their cancer experiences. Such a group allows sharing without pressure and lets the healing unfold at a natural pace. The simple act of only telling stories may be comforting, thus permitting silences that may not occur in more formal, structured communications. The differences between groups in this study concerning the use of natural, comfortable silence may indicate a more therapeutic milieu and greater cohesiveness in the storytelling group.

Despite general agreement that brief, professionally led groups can reliably improve quality of life in most patients with cancer, relatively few people use these services (Cunningham, 2000). For patients with cancer attending storytelling groups, a tool kit with a clear, straightforward guide to storytelling techniques for oncology nurses could prove useful. Such a tool kit also could help oncology nurses who work in small rural communities where their clients fear to self-disclose in groups or where no storytelling groups exist. Although a group setting for storytelling may be more therapeutic for some patients with cancer, even a few private minutes where nurses and patients come together in a caring moment (Watson, 1988, 2002) could open possibilities for healing and support transcendence in the face of suffering.

Author Contact: Bronwynne C. Evans, PhD, RN, FNGNA, ANEF, can be reached at bronwynne.evans@asu.edu, with copy to editor at ONFEditor@ons.org.

References

Abell, N. (1991). The Index of Clinical Stress: A brief measure of subjective stress for practice and research. *Social Work Research and Abstracts, 27*(2), 12–15.

Boykin, A., & Schoenhofer, S.O. (1991). Story as link between nursing practice, ontology, epistemology. *Image, 23*(4), 245–248.

Burish, T. (2000). The role of behavioral and psychosocial science in reducing cancer morbidity and mortality. *Oncologist, 5*(3), 263–266.

Carson, A.M., & Fairbairn, G.J. (2002). The whole story: Toward an ethical research methodology. *Nurse Researcher, 10*(1), 15–29.

Caserta, M.S., & Lund, D.A. (1993). Intrapersonal resources and effectiveness of self-help groups for bereaved older adults. *Gerontologist, 33*(5), 619–629.

Clarke, A., Hanson, E.J., & Ross, H. (2003). Seeing the person behind the patient: Enhancing the care of older people using a biographical approach. *Journal of Clinical Nursing, 12*(5), 697–706.

Cohen, M.Z., Haberman, M.R., & Steeves, R.H. (1994). The meaning of oncology nursing: A phenomenological investigation. *Oncology Nursing Forum, 21*(8, Suppl.), 5–8.

Cohen, M.Z., Kahn, D.L., & Steeves, R.H. (1998). Beyond body image: The experience of breast cancer. *Oncology Nursing Forum, 25*(5), 835–841.

Cunningham, A.J. (2000). Adjuvant psychological therapy for cancer patients: Putting it on the same footing as adjunctive medical therapies. *Psycho-Oncology, 9*(5), 367–371.

Diekelmann, N. (1991). The emancipatory power of the narrative. In R. Schaperow (Ed.), *Curriculum revolution: Community building and activism* (pp. 41–62). New York: National League for Nursing.

Diener, E., Emmons, R.A., Larsen, R.J., & Griffin, S. (1985). The Satisfaction With Life Scale. *Journal of Personality Assessment, 49*(1), 71–75.

Emblen, J., & Pesut, B. (2001). Strengthening transcendent meaning: A model for the spiritual nursing care of patients experiencing suffering. *Journal of Holistic Nursing, 19*(1), 42–56.

Errante, A. (2000). But sometimes you're not part of the story: Oral histories and ways of remembering and telling. *Educational Researcher, 29*(2), 16–27.

Frank, A. (1997). *The wounded storyteller: Body, illness, and ethics.* Chicago: University of Chicago Press.

Kahn, D.L., & Steeves, R.H. (1988). Caring and practice: Construction of the nurse's world. *Scholarly Inquiry for Nursing Practice, 2*(3), 201–221.

Kahn, D.L., & Steeves, R.H. (1994). Witnesses to suffering: Nursing knowledge, voice, and vision. *Nursing Outlook, 42*(6), 260–264.

Kahn, D.L., & Steeves, R.H. (1995). The significance of suffering in cancer care. *Seminars in Oncology Nursing, 11*(1), 9–16.

Kellner, R. (1986). The Brief Depression Rating Scale. In N. Sartorius & T. Ban (Eds.), *Assessment of depression* (pp. 179–183). New York: Springer-Verlag.

Kilpatrick, F.P., & Cantril, H. (1960). Self-anchoring scaling: A measure of individual's unique reality worlds. *Journal of Individual Psychology, 16*(2), 158–173.

Kingsley, E.P. (2001). Welcome to Holland. In S.D. Klein and K. Schive (Eds.), *You will dream new dreams: Inspiring personal stories by parents of children with disabilities* (pp. 216–217). New York: Kensington Books.

Kirkpatrick, M.K., Ford, S., & Castelloe, B.P. (1997). Storytelling: An approach to client-centered care. *Nurse Educator, 22*(2), 38–40.

Koithan, M. (1994). The seeing self: Photography and storytelling as a health promotion methodology. In P. Chinn & J. Watson (Eds.), *Art and aesthetics in nursing* (pp. 247–261). New York: National League for Nursing.

Leight, S.B. (2002). Starry night: Using story to inform aesthetic knowing in women's health nursing. *Journal of Advanced Nursing, 37*(1), 108–114.

Liehr, P.R., & Smith, M.J. (2000). Using story theory to guide nursing practice. *International Journal for Human Caring, 4*(2), 13–18.

Melzack, R. (1975). The McGill Pain Questionnaire: Major properties and scoring methods. *Pain, 1*(3), 277–299.

Miles, M., & Huberman, A. (1994). *Qualitative data analysis: An expanded sourcebook*. Thousand Oaks, CA: Sage.

Moules, N.J., & Streitberger, S. (1997). Stories of suffering, stories of strength: Narrative influences in family nursing. *Journal of Family Nursing, 3*(4), 365–367.

Quinn, J.F., Smith, M., Ritenbaugh, C., Swanson, K., & Watson, M.J. (2003). Research guidelines for assessing the impact of the healing relationship in clinical nursing. *Alternative Therapies in Health and Medicine, 9*(3, Suppl.), A65–A79.

Sandelowski, M. (1994). We are the stories we tell: Narrative knowing in nursing practice. *Journal of Holistic Nursing, 12*(1), 23–33.

Severtsen, B.M., & Evans, B.C. (2000). Education for caring practice. *Nursing and Health Care Perspectives, 21*(4), 172–177.

Smith, M.J., & Liehr, P. (1999). Attentively Embracing Story: A middle-range theory with practice and research implications. *Scholarly Inquiry for Nursing Practice, 13*(3), 187–210.

Smith, M.J., & Liehr, P. (2003). The theory of Attentively Embracing Story. In M. Smith & P. Liehr (Eds.), *Middle-range theory for nursing* (pp. 167–187). New York: Springer.

Spiegel, D., Stroud, P., & Fyfe, A. (1998). Complementary medicine. *Western Journal of Medicine, 168*(4), 241–247.

Steeves, R.H. (1992). Patients who have undergone bone marrow transplantation: Their quest for meaning. *Oncology Nursing Forum, 19*(6), 899–905.

Steeves, R.H. (1996). Loss, grief, and the search for meaning. *Oncology Nursing Forum, 23*(6), 897–903.

Ten Kroode, H.F. (1998). Active listening to cancer patients' stories. *Netherlands Journal of Medicine, 53*(2), 47–52.

Utley, R. (1999). The evolving meaning of cancer for long-term survivors of breast cancer. *Oncology Nursing Forum, 26*(9), 1519–1523.

Vogt, W. (1998). *Dictionary of statistics and methodology* (2nd ed.). Thousand Oaks, CA: Sage.

Watson, J. (1988). *Nursing: Human science and human care*. New York: National League for Nursing.

Watson, J. (2002). Intentionality and caring-healing consciousness: A practice of transpersonal nursing. *Holistic Nursing Practice, 16*(4), 12–19.

Watson, J. (2003). Love and caring: Ethics of face and hand—An invitation to return to the heart and souls of nursing and our deep humanity. *Nursing Administration Quarterly, 27*(3), 197–202.

Wise, C., Plowfield, L.A., Kahn, D.L., & Steeves, R.H. (1992). Using a grid for interpreting and presenting qualitative data. *Western Journal of Nursing Research, 14*(6), 796–800.