DIGITAL STORYTELLING AND TRAINING IN HEALTH CARE SETTINGS

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Abstract: This article presents a research carried out at a hospital in northern Italy where digital storytelling (DST) was used for health personnel training. A digital story is a short story narrated in the first person using multiple languages: images, music, sound and film sequences. This narrative methodology was chosen to achieve three main objectives: 1) encourage deep reflection and emotional mediation by the use of more expressive codes; 2) build a collection of digital stories produced in narrative workshops for training in health care; 3) reduce the distance between care settings and care users through the online publication of digital stories. The project phases and the results achieved are discussed.

Keywords: Digital storytelling, training health care settings, training.

Introduction

Since the mid-1990s, when we have come to the formalization of the concept and the practice of narrative medicine (Charon, 2006), there has been a proliferation of experiences that have seen narrative methodologies at the center of numerous healthcare interventions. Disease and patient histories have begun to represent a fundamental ingredient in medical practice, allowing to develop and interpret the bio-psycho-social approach in various contexts of care.

The introduction of these methodologies did not only cover clinical practice, but has led to many reflections on the use of these stories in health education. Hunter argues that the best clinical teaching is the one that comes from the patient (Hunter, 1991), highlighting how the disease stories do not deplete their function in the medical-patient dyad, but represent an important carrier for the transmission of knowledge and skills addressed both to healthcare personnel and to people in different forms of patient education.

From the Nineties onwards there are numerous projects, born in different contexts, aimed at gathering disease stories and promoting narrative processes in suffering contexts. Also thanks to this diffusion, narrative strategies and methods used in the socio-health field have known various processes of dissemination and evolution.

In this context, the use of Digital Storytelling (Lambert, 2002) has become more and more important: it is a narrative practice based on first-person narration through voice, images, and music. Digital storytelling (DST) has also been established in healthcare environments thanks to projects such as Patient Voices (Hardy & Sumner, 2014).

The research presented in this paper deals with the use of DST in the training of health care personnel according to a twofold approach: 1. Direct. Intended to promote reflective and narrative skills in professionals; 2. Indirect. It concerns the acquisition of the strategies needed to manage DST laboratories with patients.

We chose digital storytelling for a number of reasons, including:

1. Multimedality, which represents an added value especially when criticalities in the written composition may be present. The opportunity offered to the narrator to use different languages allows people to enhance their expressive ability. In addition, it offers valid strategies for the representation of complex concepts that sometimes do not find words to be the best vehicle for transmission. Multimedia opens up an aesthetic dimension that is well matched with the emotional component of the DST, especially when it has to do with nursing care.
2. Involvement. In continuity with the previous point, the use of multiple languages allows the creation of stories capable of wrapping the spectator and carrying it to an active and interpretive listening dimension.
3. The synthetic narrative that responds adequately to two needs: a) reducing the storyteller's investment of time; b) to reach the addressee in a very direct and immediate way.
4. Transmission potential. Among the characteristics of the DST there is the ability to enhance the emotional reach

of the stories, creating the appropriate ground for the definition of forms of empathy that are particularly effective in socio-sanitary communication contexts.
5. Thoughtfulness. Narration has the ability to activate forms of reflection and meta-reflection both in the storyteller and in the beneficiary. This capacity is enhanced, in DST, because every single ingredient (images, music, text) requires, to be selected, an intense activity of analysis, reflection and meta-reflection that leads the narrator to cross many often interesting and enriching paths towards self-knowledge that sometimes can be an important factor in self-care.

The research-action project is based on the collaboration between the Department of Philosophy and Education Sciences of the University of Turin and the Training Department of the Hospital of Biella, a small town in Northern Italy. The Director of Education, Vincenzo Alastra, has based much of the training and education activities directed at healthcare professionals and patients on narrative methodologies (Alastra, 2015). In this direction, different strategies have been explored ranging from cinema, literature, poetry to photographic narratives.

Materials and Methods

Does multimedia narration promote professional reflection? Which processes are triggered during shared media narration paths within professional groups? Can DST support patient narrations?
These are some of the questions from which we started when we decided to introduce the DST methodology in educational actions with operators and patients.
Specifically, the experience was carried out with two distinct groups of "narrators":

1. a group of five healthcare workers (4 nurses and 1 health-care worker) who had previously been formed on the narrative front and had activated narrative workshops with patients. The objective, in this case, was twofold: a. To stimulate a professional meta-reflection on narrative practices; b. Foster the acquisition of a new narrative competence for any other laboratories to be offered to patients.
2. a group of educators and people with mental disease (5 patients and 3 educators). Subjects belong to the same health service.

Let's start examining the experience carried on with healthcare providers. As mentioned, they had a solid professional background and worked through different narration seminars in health and education. As a matter of fact, they have followed numerous training courses in this field and they have activated at least one narration workshop in their professional contexts. The aim was to reconstruct and to make a critical analysis of these experiences with the intent of "re-rendering" them by attributing meaning and value to those aspects that in practice were lost or at least unexplored.

Because they were experts, it was decided to start using the DST both to further expand their know-how and to enable the creation of expressive forms that would allow a higher level of content sharing and the surfacing of latent meanings.

Their involvement took place on a voluntary basis and activity was carried out over a couple of months with two collegial meetings each month and part of the work done autonomously.
The DST workshop was organized in 6 phases:

1. Introductive phase. During the first meeting participants presented their participation to the lab and motivated it. The facilitators explained the working modes, the timing of work and the tools that would be used. In addition, narrative themes (dramatic questions, DQ) were defined, on the basis of which participants would tell their stories. The DQs all had a common basis that recalled the experience of narrative practice in the contexts of care.
2. Sharing stories. In the second encounter the stories, thought and written in autonomy, were shared and discussed in a group. This has allowed each narrator to make changes, to access aspects that are not considered, and to proceed to the definite writing of the story.
3. Pictures and audio accompaniment selection. Each author chose images that would allow to express and effectively represent contents and meanings of history. Once the various media elements have been identified, narrators have made the storyboard in order to make the work more linear in the next step.
4. Sharing images and music. Just as the stories have been socialized, so has been done with multimedia elements. In particular, there was a deep discussion about iconographic choices, not so much about defining the aesthetic value of the elements, but to reflect and analyze the meanings attributed by the narrators.
5. Editing. Stories have been assembled using Movie Maker, a simple sw for video editing.
6. Sharing the final product. Although all the elements of the DST had been presented and discussed in the previous phases, it was considered appropriate to devote a space to the visualization and analysis of the finished products, both to close the lab and to grasp those aspects and dimensions that only emerge in overall vision.

The second group represented a challenge from an educational and narrative point of view, both because of its size and its heterogeneous form. The group was out together in two different moments: at first the facilitators met the educators to plan the intervention, define the narrative objectives, and establish the criteria to be used in identifying the patients. The activity was proposed to those patients (all attending the same mental health service) who had already taken a certain care pathway and had reached a good level of disorder management. At a later time, educators joined the group because they wanted to share this experience with their patients to create a co-location and equality situation that was considered important at that stage of the care path.

Again, the activity was organized in phases as in the previous group, setting a timeline appropriate to the various needs of the participants.

At this stage, we will only focus on some of the moments we consider particularly interesting.

1. Involvement and definition of the narrative theme (DQ). As mentioned earlier, the identification of the people to whom the laboratory was proposed had to take into account a number of factors related to the disorder of each person, and to the potential and criticality of each individual. We chose to work with those people who had achieved good pathology control and found themselves in an existential phase of balance and change. For this reason, the dramatic question "My Life With" was proposed, which was intended to allow participants to project themselves into a "future" and generative dimension. In fact, the purpose of the intervention was to bring people to reflect on aspects of their lives that could be good starting points for a new existential design.
2. Finding and Writing Stories. This was a very complex phase that took several weeks. Operators and patients worked together in a context of strong collaboration aimed at identifying what could be told and how to do so. The two facilitators also supported the group in the choices, especially in the critical moments in which some participants expressed difficulties in identifying, in their existence, something deserving to be told.
3. Media Writing. The activity was carried out by maintaining the principle of maximum copyright and soliciting the use of original iconographic resources. When these were unavailable, storytellers organized moments dedicated to photography, in which patients and operators took the pictures they needed.

Facilitators
As mentioned above, two facilitators worked to the design of activities and managed the narrative laboratories. At the design stage, they worked on defining criteria and ways of involving patients, helping educators to define selection criteria based on the opportunities offered by this type of intervention.
Subsequently, they played a crucial role in sharing moments by managing the critical issues and by stimulating the necessary analysis and reflection to achieve a DST. Above all they encouraged in the participants an evolutionary and transformative process, with an intervention that wanted to be primarily educational and partly rehabilitative for patients and educative for educators.

Results and Discussion

We will present the results obtained, resuming the questions with which this text started.

1. Does media narration promote professional reflection?
The DST has proven to be a functional method of activating key meta-reflective processes in professional contexts. The ability to tell through different languages allows individuals to access a more creative and expressive plan than the one written. This is functional to the acquisition of knowledge and awareness (Carper, 1978).
Here are some comments that nurses from the first group expressed when, at the end of the seminar, they were invited to report their formative experience:

“This experience has allowed me to combine new skills with old knowledges, creating a versatile, simple and powerful expressive tool that can give voice to the care work. (...) This experience has prompted me to reflect on how much a nursing relationship can lead to exploring the world of beneficiary and curator emotions” (Laura)

“Realizing a DST has been the occasion to look at my work through a kaleidoscope, reassembling, in a new light, many of its components” (Silvia).

“I rediscovered the pleasure of photography, my old passion, finding old photos that I had taken and that, used in a precise sequence, expressed with all my satisfaction what I meant” (Laura)

As can be seen from the first comment, the added value of this narrative practice is represented by the possibility of expressing itself through multimediality. In addition, the choice of the different narrative components (images,

video sequences, music) enables the activation of professional memory retrieval processes and helps the professional to "put order" among the events.

2. Which processes are triggered during shared media narration paths within professional groups?
In general, there was a tendency to start very significant comparisons with regard to iconographic and editing choices. The discussions never mattered about the aesthetic dimension, but they focused on the coherence of pictures with respect to the meanings they had to represent. In addition, it should be pointed out how, tendentially, comparisons took place on a semantic plane to gradually shift to professional and emotional aspects. On more than one occasion, the empathic aspect has emerged, activated both by the personal story and by the research activity, especially of the iconic devices. Many of the operators involved claimed that the search for photographs led them to go back with their memory to experiences, facts, and people they had almost forgotten about. This has allowed them to find important pieces for the reconstruction of both personal and professional life. Although many of the nurses and educators involved in the project had already been involved in storytelling workshops and they were used to narrating their professional life, it was evident that DST has triggered reflection and analysis mechanisms which were different from what had happened with other strategies.

Another very interesting aspect is the importance of content represented by images and their impact on professionals. Although the participants of the two groups met each other, when they shared some images they had access to a deeper knowledge plan, which was precluded while reading stories. A change of perspective was noticed between the time when the narrative texts were shared and the time when the work with pictures started. It should be noted that participants were asked to only use original photographs and not to access online repertoires. This choice was motivated by both the respect of copyright and the need to minimize the risk of standardizing the performances, to allow, as much as possible, the creation of truly authentic tales.

The moments of sharing media choices have strengthened the group spirit and encouraged collaborative attitudes. This was even more intense when multimedia management has put narrators in the face of some technical critiques.
3. Can DST support patient narratives? The results of the group of people with mental discomfort lead us to assert that the narrative processes made possible within a DST path represent a scaffolding element for people with fragility. Specifically, it seems relevant in this regard to focus on some aspects that have emerged in a particular way:

1. The images facilitated the narration, especially for those people who manifested a greater discomfort in communicative and narrative processes. We take for example the experience of A., a very motivated patient suffering from severe schizophrenia, who at the beginning of the course, had manifested his difficulties in telling a story because he felt that he was absolutely incapacitated. The ability to use photographs and music has calmed down, allowing him to complete his work by achieving a high degree of satisfaction for his digital story.

2. Also in this case, as reported to professionals, sharing image selection has promoted a greater mutual knowledge among the participants. In addition, this activity has allowed forms of collaboration and, in particular, mutual support among patients. While in the "writing" phase of their story subjects kept a certain gap between them, whereas during shared media research activities it often happened that they mutually assisted and supported themselves in the face of the criticalities that sometimes the technological dimension presented to them. In particular, we mention the case of A. and S. that for several meetings ignored eachother, but when it was time to choose the images of S., A. began to participate and interact with S. activating forms of comparison to which we had never come to before. During the last meeting, when it was asked to participants what they thought about the experience they had participated to, one of them said that although they had known it for a long time, only at that time they could be considered a true group.

3. In closing, reference should be made to the effects of participation by operators and patients within the same group. A first reference should be made to the emotional climate that has been not only extremely positive and collaborative, but also serene and often fun, throughout the laboratory. Although people had exposed their weaknesses and shared very personal aspects of their existences, sometimes even particularly delicate emotionally, it was possible to maintain some joy in being "there" together to share that experience. This has been a highly motivating factor and has allowed everyone to overcome the criticalities that have emerged from time to time.
For the reasons given and for others that we do not mention here, we feel that the DST not only supported the narratives of the patients, but has allowed us to define relationships that were not built many years ago. This concerns not only the patients but also the relationships with the operators.

Conclusion

The experience with the two groups allows to highlight how DST can be a valid ally in the empowerment of people and in the self-valorization of their professional experience. With this process, the subjects involved are not just telling their professional history, but they are obliged to represent it. To do this people need to be able to reconstruct their own professional existence and to understand it so well that they can tell it through images or semantic devices that are effective but also extremely complex. Identifying the image that can properly represent a salient moment in your profession implies a strong awareness and the ability to arrange the elements that are a part of it. When reaching the goal storytellers will not just have the right photo for that specific sequence, but also a clear view of their position, their evolutionary process, and the acquired skills. This is a formidable result for people, especially for care professionals who are constantly running the risk of burnout, but at the same time it is a fundamental goal for healthcare organizations.

Other interesting aspects were observed during this experience. Here we focus on some of them:

a. During the socializing moments of the stories it was noticed that people tended to be completely absorbed by tales and, above all, much more open to communication, listening, and empathy. This aspect is fundamental when there is some social marketing aim on particular issues (mental health, disability, independent life).
b. Some participants have interpreted the story as a sort of demonstration of their ability to cope with situations and difficulties.

Inside the Biella Hospital, where the experiences have been carried out, new DST laboratories are active, always addressed to care professionals both of the hospital and other healthcare companies. This will allow us to further study this methodology and to achieve mainly two objectives:
1. to assess the actual impact on organizations;
2. to identify good practices that can be exported in contexts not strictly sanitary.

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