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Narrative Training as a Method to Promote Nursing Empathy Within a Pediatric Rehabilitation Setting

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ABSTRACT

Purpose: Empathy is deemed essential to nursing, yet interventions that promote and sustain empathy in practicing nurses within healthcare organizations are limited. We tested the feasibility and perceived impact of an arts-based narrative training intervention involving pediatric rehabilitation nurses for the purpose of promoting nursing empathy.
Design and Methods: One-group qualitative repeated-measures design at an urban Canadian pediatric rehabilitation hospital. Eight nurse participants attended six 90-minute weekly group narrative training sessions and two in-depth interviews pre- and post-intervention.
Results: The intervention positively impacted participants in three primary domains: Empathy for Patients and Families, Empathy Within Nursing Team, and Empathy for the Self. Major findings included: increased value placed on patients' and families' backstory, identification of "moral empathic distress" (MED), enhanced sense of collaborative nursing community, and renewal of professional purpose.
Conclusions: This study is the first of its kind conducted in the pediatric rehabilitation nursing context. Results indicate that arts-based narrative training enhances nursing empathy and contributes to a supportive nursing culture.
Practice Implications: In addition to enhancing empathy in clinical domains, nurses who participated in narrative training reported improved team collaboration, self-care practices, and renewed professional purpose. The results from the intervention are encouraging and future research needs to explore its utility in other settings with larger and more diverse sample.

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"Narrative medicine" has emerged as an innovative method for building empathy in health professionals. By emphasizing the role of 'story' and 'storytelling' in healthcare settings, narrative practices draw on healthcare providers' ability to listen, understand, and honour stories generated by personal experience (Charon, 2001; see also Miller, Balmer, Hermann, Graham, & Charon, 2014). Soliciting candid stories improves patient care by revealing, and eliciting compassion for, the complexity of patients' and health providers' experiences of healthcare (Charon, 2001). By seriously engaging arts-based materials including poetry, comics, visual art, and written prose, narrative medicine interventions have been shown to enhance empathy, develop reflective practice, encourage resilience and team functioning, and foster professional identity development (e.g., Cunningham, Rosenthal, & Catallozzi, 2017; Miller et al., 2014; Shapiro, Rucker, Boker, & Lie, 2006; Winkel et al., 2016).

As an arts-based healthcare intervention, "narrative medicine" has been identified as an important shift towards patient-centered care (Charon, 2001). Despite its titular affiliation with *medicine*, however, arts-based narrative interventions have been successfully employed with a range of healthcare professionals. Therefore, in keeping with research that reflects such inclusiveness (Charon, 2007; Crawford, Brown, Tischler, & Baker, 2010) this article employs the phrase "narrative training" to reflect the application of rigorous training in close reading, attentive listening, reflective writing in the *nursing* context. For example, in two different studies, interdisciplinary groups of predominantly nurses

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(59%–63%) and physicians (11%–31%) reported that narrative training positively influenced both clinical care and participants' lived experiences (Dickey, Truten, Gross, & Deitrick, 2011; Sands, Stanley, & Charon, 2008). However, narrative practices have yet to be widely adopted within healthcare environments, especially the nursing professions.

Providing nursing care to patients who are in pain, suffering, or traumatized involves intense practical and emotional challenges (Sabo, 2011). Pediatric rehabilitation nurses are at the forefront of such complex care relationships. Working with children in long-term hospitalization following painful bone surgeries or life-changing trauma (e.g., spinal-cord or brain injuries) involves navigating the needs of both patients and their family members, often including profound distress, grief, and anger (Webb, Tittle, & Vancott, 2000). Narrative training is well-suited to the demands of long-term nursing, given the prevalence of occupational stress and burnout among this group (McHugh, Kutney-Lee, Cimiotti, Sloane, & Aiken, 2011).

Principles of patient- and family-centered care (PFCC)—including *Respect and Dignity*, *Information Sharing*, *Partnership*, and *Collaboration*—are essential to effective healthcare delivery in the pediatric setting (Institute for PFCC, n.d.). Pediatric rehabilitation is no exception, requiring nurses to uphold a strong ethic of collaboration with families. The capacity to imagine the situation of each patient and their family—understanding their feelings and perspective, and responding in ways that make patients feel heard and cared for—is known as empathy (Morse, Bottorff, Anderson, O'Brien, & Solberg, 2006). Empathy therefore underpins the principles of PFCC. In the pediatric rehabilitation context, PFCC assumes its providers have the personal and institutional means to facilitate such empathetic care relationships.

Yet higher workloads, decreasing staffing ratios, and increasing technological demands (Cram, 2011) mean that empathy is under assault in the healthcare setting. Nurses report that complex chronic illness (Maytum, Heiman, & Garwick, 2004) and caregiver burnout are impediments to empathy (Bradham, 2008). Based on the essential role that nurses play in the patient's experience (Needleman & Hassmiller, 2009)—and, especially in the pediatric context, the family experience as well—it is vital that the promotion of nursing empathy is adequately and empirically addressed. For nurses to provide optimal patient care, nurses themselves must feel consistently cared for, with time devoted to "destressing" within the work context (Crane & Ward, 2016). Consequently, interventions aimed at 1) determining the specific challenges to empathy faced by nurses, and 2) better supporting pediatric rehabilitation nurses in their day-to-day work, are urgently needed.

To date, most research pertaining to narrative training's impact on empathy has focused on health professional students or interprofessional teams. This study is the first to examine the perceived impact of an arts-based narrative training intervention in the pediatric rehabilitation nursing setting.

Methods

Prior to and following a narrative training intervention (conducted weekly over six weeks), participants completed two in-depth, 60-minute semi-structured individual interviews (one interview pre-intervention and one interview post-intervention) to assess its perceived impact on nursing empathy using a one-group qualitative repeated-measures design (Patton, 2002).

Recruitment was conducted at an urban Canadian pediatric rehabilitation hospital. In light of time and resource constraints (i.e., budgetary and work/shift-related) described by study site staffing administrators, prior to the study start date, we determined that recruitment would be limited to 8 participants. Importantly, our study's pre-determined sample size was consistent with recommendations from the American Balint Society describing best practices for facilitated small-group work involving health care professionals with shared experiences (i.e., sessions should be a minimum of 60 min and involve 6–10 members); these recommendations further informed the length of individual sessions and the duration of the intervention itself (Roberts, 2012). Following institutional ethics approval, pediatric rehabilitation inpatient nurses were recruited using an internal institutional email list. At least two nurses from all three inpatient units self-selected to participate; none had previously participated in any form of narrative training. Participants provided informed consent and received an honorarium ($50 in prepaid gift-cards) for their time.

Data Collection

One-hour, semi-structured individual, pre- and post-intervention interviews were conducted approximately 8 weeks apart. Pre-intervention interviews explored participants' expectations for the intervention (e.g., "What do you hope to get from this experience?", "What was it about the program that attracted you?") while post-intervention interviews explored perceived impact (e.g., "What was the most important experience you had in the program?", "Would you recommend this program to other nurses? How come?"). All interviews were audio-recorded, transcribed verbatim, and de-identified prior to analysis. Participants reported basic demographic information, including gender and years of experience. Eight months later, 5/8 nurses (at least one from each inpatient unit) participated in member-checking (Birt, Scott, Cavers, Campbell, & Walter, 2016; Mays & Pope, 2000) to verify research findings.

Narrative Training Intervention

Curriculum Development

To ensure the intervention engaged topics commonly encountered by pediatric rehabilitation nurses, an Operations Manager, Clinical Resource Leader, and facilitator met to identify typical experiences. Facilitators designed the curriculum based on these discussions, scholarly literature on narrative training and empathy in the clinical setting, and the practice principles of "narrative medicine" (Charon, 2001). Session topics included: "The Other Side of Care," "Building Perspective," "Obstacles to Empathy," "Limits to Rehabilitation," "Making Room for Hope," and "A Letter to Myself." See Table 1 for an overview of the curriculum, including: session theme, purpose, and activities.

Narrative Intervention Session Structure

In keeping with American Balint Society recommendations for small-group work involving health professionals described above, the intervention involved six once-weekly 90-minute sessions guided by dedicated facilitators in a quiet location off-unit at the study site (Roberts, 2012). Each session began with quiet reading of a short creative work (e.g., poem or comic) addressing the session's topic. Participants then engaged in a facilitator-guided discussion of the reading, followed by an expressive writing or drawing prompt (e.g., "Write about a time that you received care"; "In a three-panel comic, tell the story of a patient through their parents' eyes"). For the remainder of the session, participants created, shared, and discussed their own written or visual narratives. Facilitators recorded personal field notes after each session to describe their impressions of the intervention. Two of three facilitators (with experience in narrative training for health professionals) led all sessions: a PhD in English who directs a Health Humanities program; a certified medical illustrator with a PhD in English; and a parent to a former inpatient at the study site and editor of a magazine on parenting children with disabilities.

Data Analysis

To ensure rigor and credibility, research team members who did not facilitate the intervention used an open-coding procedure for iterative thematic narrative analysis (Patton, 2002; Saldaña, 2009) on an initial subset of pre- and post-intervention individual interviews. The initial

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Table 1
Overview of Narrative Intervention Curriculum.

Theme	Purpose	Expressive prompt
Session 1: Welcome; the other side of care	A discussion about a time participants found themselves receiving care.	Write about a time that you or a family member received care in hospital.
Session 2: Seeing from different points of view	Examine different and sometimes conflicting perspectives of patients, parents and professionals in children's rehab.	a) In a three-panel comic, tell the story of a patient through one of his/her parents' eyes.[a] b) Now tell the story of the same patient through his or her doctor's or therapist's eyes.
Session 3: Obstacles to empathy	Discuss circumstances where it may become hard to "care" for another person: both in the sense of providing what is necessary to optimize health, and in the sense of feeling concern, compassion, and attaching importance to another person.	a) In a three-panel comic, tell the story of a time when you found it hard to care for a patient. b) In a three-panel comic, tell the story of a time when a patient (or parent) took out their grief or anger on you.
Session 4: The limits of rehab	Demonstrate the difficulty of expressing pain through language, especially when despite best efforts a child's rehab goals were not achieved.	Write about a scene of failure.
Session 5: Making room for hope	To celebrate the powerful satisfactions and successes that can be realized in children's rehab.	In a three-panel comic, tell the story about a child or family you are very attached to and the best possible outcome for them.
Session 6: A letter to myself	To reflect both on their professional experiences in children's rehab and their insights during the past five narrative sessions to compose a letter of advice to their younger self.	Imagine that it's your first day working on the inpatient unit. Write a letter to your younger self that shares your best advice.

[a] A three-panel comic describes a short visual narrative that is distributed over three single-drawing frames. As renowned comic illustrator Art Spiegelman states, "when you have a short comic, like a three-panel comic, you've got a past, a present and a future as soon as you look at those boxes" (as cited in Witek, 2007).

codebook was generated by independently coding all interview transcripts to identify emerging themes regarding nurses' perceived impact of the intervention. All six authors, including facilitators, participated in secondary coding to further inform the coding structure from the thematic response categories that organically manifested in the data. Based on this exploratory analysis, the final codebook was developed as a framework to analyze all interview material. Final thematic categories were determined using a reflexive and cyclical process of independent analysis followed by collaborative discussion involving all authors; this iterative process was repeated until themes were determined to adequately describe major patterns evident in the interview data. Using the final codebook, all authors participated in consensus coding for all interview transcripts and disagreements were discussed until consensus was reached.

Given that recruitment was constrained to eight participants, data saturation was determined to be achieved when no new data and/or themes in pre- and post-intervention data were detectable (Fusch & Ness, 2015; Guest, Bunce, & Johnson, 2006). Further evidence of data saturation was confirmed via data triangulation, which occurred through cross-verification of transcripts and facilitator field notes of identified themes (Denzin, 2009, 2012).

Results

All participants completed pre- and post-intervention individual interviews. Three narrative training sessions were attended by 7/8 participants; remaining training sessions involved all participants. Participants were female, generally between 30 and 39 years (5/8 participants), and included novice (1–2 years' experience) and experienced nurses (11–19 years) as well as nurses with 5–10 years of experience. We assessed perceived impact based on themes and subthemes derived from participants' pre- and post-intervention individual interview data.

Iterative thematic analysis revealed impacts that may be grouped into three primary themes: (1) *empathy for patients and families*, (2) *empathy within nursing team*, and (3) *empathy for the self*. Findings below include a definition of each theme and subtheme followed by shifts in behaviours, attitudes, and/or perception as reported by participants.

Empathy for Patients and Families

This theme encompassed how participants described the narrative training's perceived impact on their capacity to empathize with pediatric rehabilitation patients and families. Within this theme, three subthemes emerged pre- and post-intervention: "understanding patients and families," "negotiating direct nursing and psychosocial care," and "experiencing moral empathic distress."

Understanding Patients and Families

This subtheme referred to participants' ability to recognize and appreciate patient's/families' experiences in the care setting. Pre-intervention, participants expressed a desire to appreciate a patient's/family's perspective, but usually in the simplified terms of PFCC jargon (e.g., "*think of yourself being in their shoes*" (ID01).

Post-intervention, participants were more likely to describe how empathy can be realized in concrete terms: "*these stories helped me think, 'Okay, this is a young girl. She misses her mom. Let's just take five minutes'*" (ID06), "*trying not to be so quick to judge things and to listen better*" (ID02), and "*What comes out of my mouth will be different*" (ID03). Furthermore, participants regularly emphasized a patient's/family's unique *backstory*—the complex, often painful experiences that occur before and during the current care episode, but outside of the family's interactions with the hospital. For example, as one participant stated: "*they have to do renovations at home… or now one parent's… lost their job*" (ID04). Acknowledging patient/families' backstory as a result of the narrative intervention enabled nurses to revise strategies of interaction. For example, one participant explained:

> *On Tuesday when I was doing a port needle with a patient who has cancer… I* [*thought*], '*oh my goodness, they are sick for a long time and it seems, like, never-ending*'*… that insight that I got from the comic… it's like, 'Yeah, this must be really hard in their life*'. (ID03).

Negotiating Direct Nursing and Psychosocial Care

This subtheme described how nurses negotiate the relationship between medical-technical tasks (described by participants as "*direct nursing*") and emotional support. Pre-intervention, participants described these as competing aspects of care; for example, one participant stated: "*So we have graphs, workload graphs… a lot of documentation. A lot of that stuff, although needed, really sometimes gets in the way of what could be spent with your kids*" (ID06). Responding to institutional barriers (e.g., time pressure, expectations of professional detachment), participants prioritized direct nursing over psychosocial care (describing the latter as "*outside my nursing hat*").

By contrast, post-intervention responses elevated the value of emotional support. For example, participants stated: "*Yes, we do the technical stuff but we feel like we're so much more the emotion, the support*" (ID05), as well as "*Really taking that time to sit down, as we were experiencing in*

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the six-week [*intervention*], *right? Give them a safe space*" (ID06). Moreover, participants highlighted the beneficial potential of storytelling: "*One of the things we were talking about in the sessions was… sometimes telling* [*patients/families*] *something about your own life may put them at ease or help them relate better to the situation they're in.*" (ID02).

Experiencing Moral Empathic Distress

We coined the phrase "moral empathic distress" (MED) to describe a noteworthy and emergent concept: participants' desire to provide care alongside the recognition that providing such care may not alleviate a patient's chronic condition or pain. More specifically, MED can be considered as an internal state associated with nurses' feelings of profound helplessness, which emerges when nursing interventions are unlikely to alleviate a pediatric patient's physical pain or chronic condition. One of the participants explained: "*It takes a lot from you too, right… I try to leave the workplace – but sometimes it's disturbing when they are sick… it's disturbing when I see them suffering*" (ID07). Profound grief and feelings of helplessness were heightened by deep long-term intimate relationships developed in the pediatric rehabilitation context, as one participant describes: "*It's more like picking up your own child, right? So when we see suffering it's more disturbing*" (ID07).

Post-intervention, participants were more likely to recognize that when medical solutions fall short, emotional support for the patient/family is critical. As one participant explained:

> *Maybe there's nothing more we can do, but… what I've learned is just to be present for the family and be their support. And to hold their hand and to tell them, 'Cry and be mad, because that is normal - you're going to grieve.'* (ID04).

Participants suggested that an improved ability to cope with MED resulted from learning during the narrative training sessions that peers shared similar struggles. As one participant shared:

> *One of the other* [*nurses*]*… was reading her piece and talking about how her patient was in pain and she was trying to help and it's not helping. And in the intervention she's crying. You know, seeing how it's not just me who gets really emotional and thinks about it - it's other staff too.* (ID08).

Empathy Within Nursing Team

This theme encompassed how participants described the narrative training's perceived impact on their capacity to empathize with other pediatric rehabilitation nurses. Within this theme, three subthemes emerged across pre- and post-intervention responses: "sense of nursing community," "attitudes towards vulnerability within the nursing team," and "redefining practical nursing collaboration."

Sense of Nursing Community

This subtheme described participants' sense of community—or lack thereof—among nursing peers. Pre-intervention, participants often defined nursing community unfavourably (e.g., "*gossiping*" (ID03), "*When I first started I didn't really feel that supported. And it's a nursing culture thing that nurses eat their young.*" (ID04)), except for a few trusted relationships ("*I have my go-to good colleague on the floor that I can vent to*" (ID04)).

Post-intervention responses reflected a more cohesive sense of community that interrupted negative, often "othering" stereotypes held by novice and experienced nurses and bred compassion for peers. For example, as two participants described: "*I thought of them as having such a hard exterior, so I was surprised*" (ID01) and "*Listening to what some of the other nurses were saying made me a little more empathetic to my fellow staff. Sometimes we can be hard on one another*" (ID08).

Nurses also reported a new recognition that to work effectively, team members need to be "*observant*" (ID08) and "*in tune*" (ID08) with peers. One explained it as:

> *This is more than just about what we're doing for families and patients. This is about the nursing staff being empathetic and caring towards one another as well, so we can come to work and do our work effectively and be in a comfortable environment.* (ID08).

Attitudes Towards Vulnerability Within the Nursing Team

This subtheme described nurses' attitudes towards expressing vulnerability in the healthcare setting. Pre-intervention responses often reflected resistance to appearing vulnerable—both in the clinical context and the study itself. As one participant shared: "*I was concerned, and maybe still a little bit, sharing with the rest of the group… You're not sure who's going to be* [*in the intervention*] *and how – what they'll say*" (ID03).

Post-intervention, participants were more likely to share work-induced emotions like grief, helplessness, and regret. As one participant explained: "*The narrative intervention reinforced that you're not alone; people have those same feelings even after 30 years' experience… We cried together, we laughed together, and I didn't feel bad about it and it was okay*" (ID04).

Redefining Practical Nursing Collaboration

This subtheme referred to participants' experiences of practical clinical work with other nurses. Pre-intervention responses generally described peer collaboration as task-oriented (e.g., "*We give a lot of pain meds, so we need a lot of co-signatures… So team work*" (ID05)), suggesting that ideals of "collaboration" were often used to refer to simple or routine practical tasks (e.g., toileting, medication, lifting).

Post-intervention responses reflected a shift away from simple or institutionalized notions of "team work" towards actively seeking out peers as sources of professional reflection. As one participant shared:

> *Some of the poetry that we read or even the comics… really made you look at the experiences of both patients and nurses. And then to be able to talk about them* [*nurses*] *after, like 'What did you think about this?'* (ID06).

Participants reported being more likely to turn to each other to brainstorm, role-play, and debrief in difficult clinical situations. For example:

> *Before* [*the intervention*] *I would always ask what to do* [*but*] *now I'm trying to collaborate more with my team by bringing up, 'This is what I found. This is what I think solutions can be' and talking it out. In my general practice… I have more confidence in my team and I feel less intimidated to speak to my team members.* (ID04).

Empathy for the Self

This theme encompassed how participants described the narrative training's perceived impact on their capacity to extend empathy towards themselves. Within this theme, three subthemes were evident across pre- and post-intervention responses: "cultivating self-awareness," "asserting the self within the clinical setting," and "confronting failure." One emergent subtheme, "renewal of professional purpose," was exclusive to post-intervention.

Cultivating Self-awareness

This subtheme referred to participants' consciousness of their own thoughts, actions, and emotions. Pre-intervention, participants hoped the intervention would provide work-related coping strategies

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(e.g., "*I'm still learning and trying to control my emotions… If I can just not… freak out right away*" (ID04)).

Post-intervention, participants described narrative training as an unprecedented opportunity to address emotional wounds and traumas from past clinical experience. As one participant explained: "*It happened, like seventeen years ago. You don't realize sometimes that you haven't totally resolved something*" (ID05). Several participants described the intervention as a way of generating an improved understanding of their own personal rather than professional or relational behaviours. For example:

> *We as individuals wouldn't be able to go to a psychologist or a social worker and get them to help us through it, because no one really understands fully like the people you're working with.* [*The intervention was*] *like therapy on a whole different kind of level.* (ID01).

Asserting the Self Within the Clinical Setting

This subtheme described participants' willingness to address their own emotional and self-care needs within the clinical environment. Pre-intervention responses often described reactive ways of coping with work-related stress (e.g., "*I would go myself and cry in one of the rooms. But that's not a good habit as a nurse*" (ID07)) and dilemmas presented by PFCC principles (e.g., "*It's hard to split yourself. Somebody wants something and somebody else wants something*" (ID05)). Nurses regularly described struggling to absorb difficult or abusive behaviours in patients, parents, and co-workers. For example, as one participant described:

> *You want to be able to stand up for yourself, but it's hard to figure out that line with family-centered care. Professionally, too, right? You want to be able to assert yourself, to stand up for yourself, but finding the line to keep it professional, to keep it therapeutic. That's hard.* (ID08).

Post-intervention responses expressed an evolved nursing identity that was more comfortable with ambiguity (e.g., "*Not being so scared to tell them I don't know… because we don't have all the answers*" (ID03)) and proactively self-caring. As two participants described: "*It means not overworking your body, like not working more hours than you're physically capable of, making sure you take your breaks at work, making sure you've made time to do fun things outside of work*" (ID02) and "*The discussions with the other nurses, the readings, really hit me… We're always so focused on others and it's, 'Well, wait. What about you?'*" (ID04).

Confronting Failure

This subtheme described nurses' perceptions of professional inadequacy. Pre-intervention responses described an intense desire to avoid failure at all costs (e.g., "*I need to learn to not—try not to take it personally, but you do. Because you feel like it's your fault even though it's not*" (ID04)).

Post-intervention, participants were less inclined to fixate upon mistakes, acknowledging the need for humility and self-compassion. As one participant described: "*Not being so upset with myself when things don't go right. Like, doing a catheter and missing like would really stress me out… It's not necessarily causing them harm, but it's just taking more time*" (ID02). Participants were more likely to adopt this stance knowing they were not alone. For example, one participant stated: "[*The intervention*] *confirmed that it's okay if I don't know because not everyone knows everything either. I can see how that shift happened throughout the weeks*" (ID01).

Renewal of Professional Purpose

Exclusively post-intervention, participants expressed pride in their expertise and the nursing profession more broadly. For instance, one participant explained: "*the once-a-week* [*intervention*] *really brings you back to the purpose of my role, or one of the most important aspects of my role*." (ID06). Sharing stories boosted confidence by confirming nurses' profound influence on patients/families' healthcare experiences. One participant shared:

> *I felt good about myself being a nurse being part of the group… because it gives me in-depth thinking of what nurses, especially the discussions we had, how much we are doing right like in terms of client care… I felt great being a nurse and proud of myself.* (ID07).

As a result of narrative training, participants described a renewed sense of professional purpose that confirmed why they became nurses in the first place. As one participant explained: "*I'm impacting people's lives… I think we forget how much we do here. Just talking about it, listening to the other staff's experiences here and elsewhere, it makes you realize how important your role is*". (ID08).

Discussion

Our study described the perceived impact of a six-week arts-based narrative training intervention aimed at promoting empathy in pediatric rehabilitation nurses. Rigorous qualitative analysis revealed 1) participants' positive perception of narrative training and 2) the intervention's "triple effect" in three primary areas, which we identified as "themes": empathy for patients and families, within the nursing team, and within individual nurses themselves. Emergent subthemes remained constant pre- to post-intervention; however, post-intervention responses usually reflected greater richness and concreteness (reflected in participants' shift away from patient- and family-centered care (PFCC) jargon to more deliberate, nuanced responses). Findings determined the existence of MED—a new concept not yet described in the literature—to describe feelings of profound grief and helplessness experienced by participants when clinical interventions are unlikely to alleviate a patient's long-term condition. Finally, one subtheme, "renewal of professional purpose," emerged exclusively post-intervention, suggesting the role of narrative training in generating a more reflective, empathic, sustainable, and sustaining pediatric rehabilitation nursing work environment.

Implications for Clinical Practice

Our findings have direct implications for clinical practice. Within the subtheme "*Understanding Patients and Families*," post-intervention nurses re-prioritized task-oriented care—a necessary but instrumental approach (Acebedo-Urdiales, Medina-Noya, & Ferré-Grau, 2014)—equally with story-oriented care practices. Similarly, participants emphasized the necessity of creating space and time for soliciting "backstory" (i.e., the portion of the patient's healthcare journey that unfolds outside the current episode of care) as opposed to limiting the scope of patient relationships to a treatment-focused patient "history": a shift that sociologist Arthur Frank (2010) describes as allowing one's illness experience to "breathe". With respect to pediatric rehabilitation, developing a rich appreciation of backstory could involve recognizing the impact of an acute care stay or, as is often the case in pediatric rehabilitation, the years of therapy and interventions needed by a child with a congenital disability and the ripple-effects of a pediatric patient's diagnosis and treatment on family caregivers. Understanding the patient's backstory as fundamentally intertwined with family experience during hospitalization adds another layer to Morse et al.'s (2006) conceptualization of empathy, where nurses respond in ways that make patients feel heard and cared for. Although active listening and effective communication are already foundational to patient centered care, such principles are often reduced to empty institutional jargon (e.g., "*put yourself in their shoes*"). In contrast, narrative training's effectiveness appears to spring from storytelling's ability to generate a more embodied realization of these underlying realities of pediatric rehabilitation nursing.

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An unexpected result was our discovery of MED, which may be unique to the rehabilitation nursing context or other similar contexts where nurses may experience profound grief or helplessness (e.g., ICUs, long-term care facilities). Distinct from "moral distress", defined elsewhere as healthcare professionals' compromised ability to pursue the "right" course of action in light of *external or organizational constraints* (Whitehead, Herbertson, Hamric, Epstein, & Fisher, 2015), MED describes healthcare providers' profound feelings of grief or helplessness *when pursing the "right" course of action is unlikely to improve a patient's condition*. In the rehabilitation context, regaining a patient's pre-admission function (e.g., walking) may not be feasible. Especially post-intervention, participants described the difficulties of caring for children with severe trauma, disabilities, and complex care needs alongside managing—more or less effectively—improbable expectations for recovery expressed by patients, families, and occasionally other health professionals. As Sabo (2011) writes, "When a healthcare system places greater value on curative intent than on supportive care, situations, such as futility of care, may occur. For nurses involved in providing such futile care, the lasting imprint may be vicarious traumatization" (Vicarious Traumatization, para. 2). Although participants continued to articulate profound MED regarding their inability to "fix" patients, post-intervention, nurses drew strength from the realization that 1) their emotional presence may suffice as a healing action, and 2) peers in the rehabilitation context are similarly affected. To ensure high quality clinical care, staff satisfaction and retention, healthcare organizations must address whether MED is a barrier to empathic care. Our findings suggest that MED may contribute to why nurses have been described as "wounded healers" (e.g., Conti-O'Hare, 2002), but also that an arts-based narrative intervention might help nurses mitigate its effects.

MED may therefore be considered in light of related concepts such as compassion fatigue (Lombardo & Eyre, 2011), vicarious traumatization (Sabo, 2011), and secondary traumatization (Beck, 2011) already used, to describe the potential psychological and emotional impact of nursing work. In general, these concepts appear to share some common characteristics with MED such as 1) witnessing a patient's suffering, and 2) the emotional response a situation elicits in the nurse or healthcare worker. However, MED appears to differ from these traditional concepts because it involves a longer and singular relationship between the nurse and patient (and, in the pediatric setting, a patient's family as well). Whereas compassion fatigue, vicarious traumatization, and secondary traumatization have been linked to interactions or experiences beyond a singular patient (often including workplace or organizational environment factors which may play a significant role in the development of stress (Sabo, 2011)), in our study, nurses regularly acknowledged deep connections with patients and their families. Also, MED may differ from compassion fatigue and other forms of traumatization with respect to the severity of the emotional and psychological impact on healthcare providers. Our results suggest that although nurses acknowledged profound emotional strain or grief concerning their inability to change the circumstance of the patient, working with the patient—as opposed to trying to change or "fix" their clinical status—was part of the nurse's work. Perhaps one way to describe the affective basis of MED is that nurses may be grieving the loss of the idea that changing the patient's circumstance is possible. However, it is vitally important to note that nurses' realization that their work remained valuable by being emotionally present to their patients was directly derived from the narrative intervention.

While MED may result in a nurse feeling helpless, our study suggests that an important element of MED is the possible acceptance of his/her helplessness. As such, MED may be quite distinct from descriptions of compassion fatigue and traumatization in the scholarly literature, which emphasizes the negative transformation of healthcare workers' inner experience, resulting in feelings like affective numbing or irritability (El-bar, Levy, Wald, & Biderman, 2013; Sabo, 2011). Alternatively, it may be plausible to think of MED as the first stage of an emotional response to patient suffering that lies along a continuum that develops into complex forms of distress for nurses. However, it may be too soon to affirm such distinctions or similarities, and therefore imperative to continue to explore and conceptually clarify the concept of MED.

Implications for Nursing Teams

The subtheme "*Sense of Nursing Community*" illustrated how narrative training was an effective method for improving peer respect, particularly the historically-fraught relationships between novice and experienced nurses (as reflected in as participants' recounting of destructive professional mottoes like "*nurses eat their young*") (Christie & Jones, 2013). Future studies might explore the impact of facilitating intergenerational narrative training with novice and experienced nurses as part of mentorship and/or orientation models. Furthermore, narrative training resulted in enhanced tolerance and compassion for vulnerability (subtheme: *Attitudes Towards Vulnerability Within the Nursing Team*). Our findings demonstrate how stories generated through narrative training can unmask work-related traumas, and the vulnerabilities of nurses, helping them confront and reckon with their fallibility. Healthcare providers' unrealistic performance expectations are associated with increased stress, inefficiency, and burnout (Childs & Stoeber, 2012). These results indicate one concrete approach to supporting a more realistic professional culture of fallibility (Melrose, 2011). One that helps, rather than stifles, nurses' ability to manage the profoundly emotional work of rehabilitation and healthcare more broadly ("*I smile more, I laugh more, I joke around more… I think maybe because it's having the confirmation that everything I've felt is normal so I don't have to stress out about it so much.*" (ID04)).

Implications for Reflective Practice

Creative methods have been shown to encourage self-renewal in the nursing work environment (Brown, 2009). Providing a safe, welcoming space where nurses could see their experiences reflected in their colleagues resulted in post-intervention responses that described narrative training as a creative self-caring practice (subtheme: *Asserting the Self Within the Clinical Setting*). Moreover, the benefits of narrative training became apparent beyond individual investments in self-care by generating the exclusively post-intervention subtheme "*Renewal of Professional Purpose*," suggesting its potential as a broader institutional intervention. Currently, healthcare systems are not well organized to support professional renewal and excitement. Our results indicate how narrative training may contribute to a compassionate culture of nursing (Rytterström, Cedersund, & Arman, 2009), something Turkel and Ray (2004) have deemed a "moral responsibility" for nursing leadership and better patient care. Our post-intervention discovery of participants' spontaneous sense of renewed professional purpose, confirms how facilitating mutually supportive pillars of empathy (i.e., between self, team, patients/families) contributes to a nursing culture that protects against burnout and compassion fatigue, while providing concrete practices for improving patient care.

Limitations and Future Directions

We acknowledge several limitations. Participants were exclusively female, self-selecting, and likely predisposed (in either attitude or openness to behavioural change) to participating in an arts-based intervention aimed at enhancing empathy. Our sample size clearly presents a further limitation; however, a larger study at the site would have negatively impacted patient care by taking more participants out of clinical care duties to participate in the narrative training sessions. While the power of the current findings may be diminished by limited sample size, it is difficult to imagine a convincing rationale for larger-scale studies without the evidence basis our findings establish here.

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Future studies may benefit from increased quasi-experimental or experimental design (e.g., randomization, control measures, sample size and power calculations). For example, a future study could implement a switch replications design, where two additional nursing participant cohorts would be selected in order to execute three waves of measurement (with instruments that assess nurse characteristics that include empathy or other relevant empathy measurement tools (Yu & Kirk, 2008)). In phase one, both groups of nurses would be pretested; one group would receive the narrative training intervention and then both would be post-tested. In phase two, the original comparison group would be given the program while the original intervention group would serve as the "new" comparison group. Although a quantitative approach would be one way to measure the effectiveness of the intervention, the paucity of data concerning the impact of narrative training in the rehabilitation nursing context justifies the rigorous, if exploratory, qualitative approach taken by this study. Future studies could also include a mixed methods research design, using the qualitative components described by our study and quantitative measurements on key nurse characteristics and patient care before and after the narrative training. Future research could also focus on clarifying the intervention's most significant features (e.g., small group setting, facilitator personality or style, types of readings), and "dose effect" considerations (i.e., how much narrative training confers maximum benefit, especially in light of institutional constraints on time and shift coverage) (Bishop, 2008). Despite limitations, this study extends the scholarly literature by articulating the perceived impact of narrative training on nurses in the pediatric rehabilitation context.

Conclusion

Narrative training in the pediatric rehabilitation nursing setting enhances empathy in three major areas and contributes to a supportive nursing culture. Unlike the corporate world, where team-building is a regular part of organizational mandates, practical, low-cost, effective team building initiatives are rarely prioritized in healthcare—despite it being an environment where high-functioning teams are required to make life-changing decisions and provide safe, quality, and compassionate care. Our findings indicate that when a healthcare organization places a group of nurses into an arts-based narrative training cycle, there appears to be a positive effect on empathy for patients, empathy between nurses on nursing teams and the ability for nurses to grow increasingly more self-aware of the emotional and social impacts of their work. Our results demonstrate that in the pediatric rehabilitation healthcare, storytelling through narrative training may be a promising intervention tool that humanizes the clinical environment and permits nurses to share, legitimize, and make meaning of complex care experiences.

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Declaration of Interest

Dr. Keith Adamson and Michelle Balkaran both held managerial roles at the study site during the research study. As such, both investigators did not have a role in data collection and did not engage with any participants. For data analysis, they were only given access to de-identified data. Moreover, it was made explicit to the participants that their participation would not affect their employment in any manner.

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