Words, Camera, Music, Action: A Methodology of Digital Storytelling in a Health Care Setting

Michael Lang¹, Catherine Laing¹, Nancy Moules¹, and Andrew Estefan¹

Abstract
In this technological age, storytelling is moving from oral and written to digital formats, creating many methodological opportunities for researchers and practitioners. This article explores a specific genre of participatory media production, digital storytelling (DST), which could be a valuable research tool to describe, analyze, and understand the experiences of research participants. Digital stories (DS) are short movies that use images, videos, a voice-over, and various video editing techniques to share an important story from the participant’s life. In a health care setting, DS can be used as knowledge translation tools for education and advocacy, as data to be analyzed in the research process, or as a therapeutic intervention, in any combination, depending on the intent of the project. Although an increasing number of health-related research studies indicate using DST, or some variation of it, there is a glaring paucity of methodologically focused manuscripts in the health care literature. This article delineates and describes four primary phases of DST in a health care context as finding the story, telling the story, crafting the story, and sharing the story. Both the creative and technical considerations of DST facilitation are elucidated through specific examples and practical concepts. By drawing from diverse literature such as narratology, film, and psychotherapy, and exploring new creative tools and ideas to help research participants convey meaning, this article provides a starting point for qualitative researchers to explore the use of DST in their own contexts.

Keywords
methodology, digital storytelling, illness and disease, lived experience, empowerment, art-based research

Everybody is a story. When I was a child, people sat around kitchen tables and told their stories. We don’t do that so much anymore. Sitting around the table telling stories is not just a way of passing time. It is the way the wisdom gets passed along. The stuff that helps us to live a life worth remembering. (Remen, 2006, p. xxxvii)

The literary critic Kenneth Burke wrote “stories are equipment for living” and are central to daily living, filling both our waking and sleeping hours (McKee, 1997, p. 11). Even before the printed word, oral traditions carried people’s stories—preserved with the goal to educate, empower, teach, warn, or connect (Gazarian, 2010; Knowles & Linn, 2004). It has long been the tradition of human beings to pass along wisdom through storytelling (Remen, 2006).

In this technological age, however, storytelling has begun to take different forms, moving from oral and written to digital formats. In developed countries, generations born after 1980 are described as digital natives (Prensky, 2001), never having known a world without computer screens and instant access to the Internet. This communication revolution has led to a fundamental shift in how stories are told and consumed (Bennett, Maton, & Kervin, 2008). No longer bound by a physically present storyteller or written word, we now have instant access to a digital world capable of transmitting stories across continents and cultures (Briant, Halter, Marchello, Escareno, & Thompson, 2016; Davis, 2004; Lal, Donnelly, & Shin, 2015; Sawyer & Willis, 2011; Wexler, Gubrium, Griffin, & DiFulvio, 2013). At no other point in history have stories had the potential to quickly and substantially influence the world. The kitchen table has never included so many voices.

¹ Faculty of Nursing, University of Calgary, Calgary, Alberta, Canada

Corresponding Author:
Michael Lang, Faculty of Nursing, University of Calgary, 2500 University Dr NW, Calgary, Alberta, Canada T2N 1N4.
Email: mlang@ucalgary.ca
Now that it is relatively easy to record, create, and share stories, researchers have turned their attention to employing digital tools to do this in therapeutic, pedagogic, and knowledge-generating ways (Haigh & Hardy, 2011; Laing, Moules, Estefan, & Lang, 2017a, 2017b; Rossiter & Garcia, 2010). One popular methodology is photovoice, which provides participants with cameras to document their daily health and work realities and then use these photographs as the basis for group discussion, research, and advocacy (Wang & Burris, 1997). Digital storytelling (DST) is a different methodology that guides participants in the creation of short movies that tell the story of their experiences; movies which may or may not use a participant’s own photos and videos (Lambert, 2013). DST is a valuable health research tool that could be utilized to describe, analyze, and understand the illness experience. In this article, we will outline the process of creating and sharing digital stories (DS) in a health care research setting that provides both therapeutic benefit for research participants and a deeper understanding of the research topic.

Background
In the Internet age, the terms “digital” and “storytelling” have become ubiquitous, often combined to mean “telling stories with digital technologies” (Alexander, 2011). Some fields of study (e.g., business, arts and humanities, health care, education) have developed their own frameworks and definitions of DST. In this article, we refer to DST as a very specific process and product that draws its theoretical foundations from the arts, humanities, and human sciences (Lambert, 2013). The process of DST includes unique facilitation components, skills, and techniques that help participants create meaningful DS about their life. The product of this DST process is a short, 3–4 min “mini-movie” (DS) that uses images, videos, a voiceover, and various video editing techniques, to share an important story from a participant’s experience.

The earliest form of DST can be found in the National Film Board of Canada short film “City of Gold” written by Pierre Burton (Daly, Koenig, & Low, 1957; Tibbetts, 1995). This film used panning and zooming to create a sense of movement in still photographs while the narrator told the story. However, it was the documentary films of Ken Burns that made the technique of using still photographs in film mainstream (Tibbetts, 1995). A further extension of this technique in a noncommercial capacity was first articulated by Dana Atchley and Joe Lambert of the StoryCenter in Berkley, CA (Woletz, 2008). In the 1980s, Lambert and Atchley began facilitating workshops with laypeople where they used personal photographs to visually illustrate a story from their lives. In Lambert’s (2013) book, Digital Storytelling: Creating Community, Capturing Lives, he offers an overview of the history, process, and product of DST. In the early years of audiovisual media, Lambert and others who followed him, discovered that the creation and screening of DS can have a powerful and sometimes therapeutic effect on both the audience and the storyteller (Haigh & Hardy, 2011; Laing et al., 2017a, 2017b; Laing, Moules, Sinclair, & Estefan, 2019; Lal et al., 2015; Lambert, 2013). For this reason, DST practitioners have always held a deep appreciation for the connection between storytelling and health (Lambert, 2013).

Health care, like many sectors, is currently experiencing a storytelling renaissance (Rose, Mason-Lai, Brocke, Page, & Cawthorpe, 2016). This is facilitated in part by the convergence of influential ideas of narrative medicine (Charon, 2001; Holmgren, Fuks, Boudreau, Sparks, & Kreiswirth, 2011), reflective practice (Schön, 1983, 1987), patient engagement (Carman et al., 2013; National Academies of Science [NAS], 2011), person-centered care (NAS, 2001), participatory action research (Koch & Kralick, 2006), and the emerging discipline of the health humanities (Crawford, Brown, Baker, Tischler, & Abrams, 2015). In this new environment, there is a growing interest in using DST from both the patient and health care provider perspective.

Currently, there are four primary approaches to DST use in health care: (a) health care provider education and quality improvement (Alberta Health Services [AHS], 2019; Christiansen, 2011; De Vecchi, Kenny, Dickson-Swift, & Kidd, 2016; Moon, 2010); (b) advocacy/public health (Briant et al., 2016; Gazarian, 2010; Gubrium, 2009; Haigh & Hardy, 2011); (c) research (Laing et al., 2017a, 2017b, 2019); and (d) as a therapeutic intervention (Akard et al., 2015). Although an increasing number of health-related research studies indicate using DST, or some variation of it, there is a glaring paucity of methodologically focused manuscripts in the health care literature. Health care is a unique setting to employ DST, as therapeutic intent, in addition to knowledge acquisition, is inherent in all our activities.

Multiple studies were recently completed to explore DST as a psychosocial intervention with patients (Laing et al., 2017a, 2017b, 2019). They found that DST not only held therapeutic potential for this population but also provided opportunities for education, quality improvement, and advocacy with the professionals who cared for them. While the DST process used was based on Lambert’s (2013) work, it was found that in a health care setting, where patients and family members lead complex, busy lives with many appointments and treatments, a more flexible and fluid process was required (Laing et al., 2017a, 2019). In the same way that all good stories have a form but do not follow a formula (McKee, 2017), facilitating a meaningful DS experience in a health care context has an essential form but does not follow a formula. It is this basic “form” and specific elements that could be considered as part of the “craft” of DST, that will be explored further in this article to provide starting point for qualitative researchers to adapt DST to their own contexts.

Research Design
In the research projects that inform this methodology article, a process was developed to work with a single participant over three 2-hr sessions to create the DS, ending with a facilitated screening of the story. This three-session time frame is not part
of the essential form of DST in a health care setting; any time frame can be used if the four basic phases of DST facilitation are completed. These are (a) finding the story, (b) telling the story, (c) crafting the story, and (d) sharing the story. Generally, the first session involved working with the participant to find and write (tell) the story; the second and third sessions involved crafting the story. Finally, the digital dissemination facilitated DS screening experience, where family and friends, health care professionals, or other patients and families viewed the story, completed the sharing the story phase. The specific details of participant recruitment, data collection, and analysis of these research projects are provided elsewhere (Laing et al., 2017a, 2017b, 2019); however, it should be noted that this article is also informed by the first author’s experience of facilitating the creation of over 300 DS with patients and their families in a health care setting.

The DST Process

Finding the Story: Meaning in the Mundane

So, it wasn’t easy, to share my story, but I guess it’s being able to step back from those immediate moments, and look at them a little more objectively. It really helps to make sense of things, make meaning, and see how your [healthcare] story is connected to other pieces of your life. (Participant quote; Laing et al., 2017a)

Empirically, psychotherapists have explored the connection between storytelling and mental health for many years under the auspices of narrative therapy, first developed by Michael White and David Epston (Angus & Greenburg, 2011; Brown, 2007; Crossley, 2000; White & Epston, 1990). A narrative therapy approach recognizes people as experts about their own lives and views problems as being separate from individuals (White & Epston, 1990). It is an approach to counseling that involves re-authoring or re-storying critical life events with the intent for them to be experienced and understood differently (White & Epston, 1990). Using storytelling in psychotherapy enables participants to reconstruct their experiences into coherent stories, allowing them to make sense of, or ascribe meaning to, traumatic experiences and move forward in their lives (Angus & Kagan, 2013; Angus & McLeod, 2004; Greenberg, 2004; White & Epston, 1990). In a subtle and compelling way, DS provides an opportunity for these same processes to occur as participants enter their stories, name their emotions, assimilate their health care experience into their life stories, and re-form (reconstruct) their identities after an illness or injury. This is accomplished throughout the entire process, but it is the primary activity of the finding the story phase.

During this phase, the DST facilitator’s role is to help the participant step back from the uninterrupted stream of life experiences to see the story that is unfolding. The facilitator can help the participant accomplish this by (a) listening deeply and following leads, (b) understanding the core archetypes and plots of illness stories, and (c) connecting “life events” and “health events” through a theme. The primary outcome of this phase of DST facilitation is for the participant to distill meaning from not only profound events but sometimes even what might be thought of as ordinary events of their lives.

Listen deeply and follow leads. The ability to listen deeply to the stories of others and follow leads is the foundation from which understanding occurs (Moules, McCaffrey, Field, & Laing, 2015), and therefore, these are core tasks of DS facilitation. This practice of listening deeply and following leads can be cultivated by recognizing that individual stories are a dialogue between two or more stories (Frank, 2012). The DST facilitator is an active participant, not a detached, objective observer, and should be willing to contribute his or her own experiences and imagination to the process. Frank (1997) emphasized this mutuality as thinking “with” a story versus thinking “about” a story. DST facilitation in a health care setting is a mutual exploration of the human health experience, not a one-way examination of participants’ health care stories. A DST facilitator is not holding a magnifying glass to the participant but walking beside them through the twists and turns of their life. Both the facilitator and participant, together in conversation, decide what pieces of the story resonate and which leads to explore in the story-writing process.

It is important to recognize that, as a DST facilitator engages in this dialogue with participants, dialogue may point the story in a new direction, leaving behind or covering over other important life events. However, pointing a story in a new direction is not necessarily a bad thing (Moreira, Beutler, & Gonçalves, 2008). For a DS to have the intended therapeutic effect for participants and cultivate a deeper understanding of the health-related topic being explored, a fundamental question must be answered: “How well are they served by their stories?” (Frank, 2012, p. 49). Is there a hidden story that needs to be told? In this way, directing a participant story toward a different theme and plot structure could be an important outcome of the DS process. However, it is important to be aware of the thin line between “being in” conversation and “leading” a conversation. Cultivating an attentiveness to our own words and actions is an important part of finding a balance between “being” and “leading” in the co-creative process of DST.

Understanding the core archetypes and plots of illness stories. The field of literary narratology (Abbott, 2002; Bal, 1997; Fludder, 2009) provides a plethora of archetypes and plot structures that can help DS facilitators ask good questions and organize life events into story form. A basic theoretical understanding of common illness story archetypes and plot structures enhances listening skills as it gives “a simple structure for what to listen for” (Frank, 2012, p. 49) and can also help DS facilitators encourage the re-storying of negative health experiences through positive plot structures.

Frank (1997, 2012) provided a helpful typology for illness stories that are encountered in a health care setting: restitution, quest, and chaos stories that can be told from both the perspective of a patient or family caregiver. Restitution stories give an account of an illness that health care professionals treat and...
resolve. Chaos stories have multiple and complex issues that are not resolved (Frank, 1997, 2012). A quest story chronicles the journey through an illness and the obstacles that the storyteller had to overcome (Frank, 1997, 2012). Early in the first meeting with a participant, it is possible to determine the archetypical structure of the story depending on where a participant is at in their health care experience. Chaos stories are common in participants relatively close to a significant illness or injury who are still dealing with significant health-related challenges. Restitution and quest stories are common when working with participants who have fully recovered and/or have had sufficient time to come to terms with their new health reality. This said, there are many overlaps and, like all typologies, contradictions and divergences, such as when chaos stories intertwine with quest and restitution stories. We offer that stories are much less structured and compartmentalized than what a typology can categorize and frame, and Frank’s typology is simply a helpful starting point to understand the stories that could be shared in a health care context.

While a theoretical knowledge of illness story archetypes supports understanding of the stories that are heard, knowledge of plot structures can assist in helping participants shape their story with a therapeutic effect in mind. In this area, the genre classifications of Friedman (1955) and McKee (1997) are useful for DS facilitation. Specifically, positive plots of character and thought, such as maturation, reform, education, and revelation, provide therapeutic potential for the participant as they focus on transformation through adversity and can reframe the suffering that patients and families face. These plots, and the reasons people identify with them, create potential to find meaning in suffering.

Connecting health events and life events through a theme. McKee (2017) defined creative talent as the ability to connect two seemingly unrelated things to create a “third thing” that is new. Helping participants create a meaningful third thing through connecting health care experiences to other events of their lives is the creative engine of DST in a health care setting. This is the most difficult process to describe and yet is the most essential.

When we tell stories, nothing is as it seems (McKee, 1997), and asking “What is this story really about?” is important to find the story theme. A helpful practice is to ask participants to describe the most memorable moment (positive and negative) of their health care experience and then of their lives. Listening deeply into these moments often reveals the underlying theme that connects them. Examples of themes from our research include letting go, being known, parenthood, discovering oneself, resilience, new perspectives, or a search for meaning (Laing et al., 2017a).

A strong theme can meaningfully connect the seemingly random events of a participant’s life. For example, in one research study with young adult (YA) cancer survivors (Laing et al., 2017a), Josh (pseudonym) struggled with body image issues after his cancer treatment. When asked why, he told the story of being transformed from an Olympic-level kayaker into “two-hundred and ten pounds of atrophied muscle and water retention” (https://youtu.be/rZCUHfGk6cw). When asked how he currently viewed his body (3 years after finishing cancer treatments), Josh shared a story about getting back on the river with a group of other YA cancer survivors of his age. At the end of the trip as a ritual of something he wanted to leave behind, he threw a stone into the river on which he had written “how I view my body.” The themes of this story—body image, letting go, and acceptance—quickly became apparent through these two moments. Once a potential theme of a DS is revealed, the facilitator and participant together can find the other story moments connected to this theme. The goal is “to select only a few moments but give us a lifetime” (McKee, 1997, p. 31).

Through a disciplined openness, understanding the core archetypes and plots of illness stories, and creative talent of the DS facilitator, participants may come to see the third thing (a theme) in their illness stories. The ability to find the story that needs telling in someone else’s life is the hallmark of a skilled DS facilitator, and this phase of DST facilitation should be the least formulaic. However, in the DST literature, this initial phase is dominated by a programmatic element called the “Story Circle” (de Jager, Fogarty, Tewson, Lenette, & Boydell, 2017; Lambert, 2013). It is important to acknowledge that when working in a health care context with ill patients and busy family caregivers, attending a multiday, group DST workshop with a formal Story Circle is not feasible. Therefore, despite the high importance of group sharing (i.e., the Story Circle) is accorded in the DST literature, we believe that DST facilitation in a health care context should focus on the underlying mechanisms described above and not on one specific programmatic element. Either way, effectively facilitating the process of finding the story takes practice and requires open-ended questions, meaningful back-and-forth conversation between facilitator and participant, and curiosity. Helping people find, understand, and ascribe meaning to both the profound and ordinary events of their lives is the primary mechanism through which the therapeutic value of DS can be realized.

Telling the Story: Manifesting Life Lessons

It’s a side of me that a lot of people didn’t know about or didn’t see… People have their secrets. And um…it’s been kind of cool opening up this part of my life to them because they see a different side of me… and just kinda like…the story of who I am. (Participant quote; Laing et al., 2017a)

When patients and families are asked to share their health care story, they often provide a chronological listing of health events that they believe are relevant; however, a simple listing of events creates a flat, emotionless, technical account (Tilly, 2006). A story, on the other hand, is full of emotional peaks and valleys with a fundamental change in the “value-charged condition of the character’s life” (McKee, 1997, p. 57). Compelling DS seamlessly connect the occurrence of health events with context and meaning in a participant’s life. For this reason, once the general concept for the story is decided upon in the
first phase, the DST facilitator must help the storyteller choose, order, and write the events of their illness story so that the theme is manifested in a story plot. Facilitators can accomplish this by helping participants (a) follow classical story structure and principles, (b) emphasize subtext and imagery, and (c) address external, internal, and philosophical conflicts. The primary outcome of this phase is to help participants succinctly but powerfully communicate the lesson embedded in their stories using only 300–500 words.

**Follow classical story structure.** Conversations of story substance and structure go as far back as Aristotle and can be complex (Halliwell & Aristotle, 1998; McKee, 1997). As DS are 3–4 min long, the simple five-phase story structure identified by Freytag (1995) is a useful place to start. Freytag’s five phases, called Freytag’s Pyramid (1995), consist of exposition (ending with the inciting incident), rising action, climax, falling action, and resolution. When each of these phases is included, a DS is likely to be comprehensible and substantial to both participants and audiences with which they choose to share the story. As a 3-min DS can contain a limited number of story events, using Freytag’s pyramid allows a DST facilitator to tactfully and efficiently help participants narrow down a very large health care story to the most salient components.

Asking the question, “What does the audience need to know to understand the story climax?” is a simple way to help participants determine the essential story events. In Josh’s story, for example, once the climactic moment of throwing a rock labeled “how I view my body” into a river was chosen, the next step was selecting the appropriate life events that helped the audience understand why throwing that rock into the river was so important. These life events included international kayaking competitions, a brain tumor diagnosis and treatment, weight gain and muscle atrophy, and finally a trip down the Colorado River with other YA cancer survivors.

**Emphasize subtext and imagery.** Once the theme of the story is decided, it can be easy to state this message directly to the audience (e.g., cancer teaches you about what matters in life). In screenwriting, this is called “writing on the nose” (McKee, 1997). In this process of moving the theme to the subtext using compelling story moments and imagery, there is potential for both participants and audiences to come to a greater understanding of their own experiences (Laing et al., 2017a, 2017b, 2019).

**Address external, internal, and philosophical conflicts.** Powerful stories address multiple, interrelated levels of conflict: external, internal, and philosophical (Miller, 2016). In a health care–related context, stories that focus on external conflict explore what happened and read as a chronological, technical account of the experience (Tilly, 2006). External conflicts can include the challenges of treatment, navigating the health care system, financial difficulties, or the recovery process from illness or injury. Internal conflicts, on the other hand, address the internal world of the protagonist: their thoughts, feelings, doubts, fears, insecurities, hopes, and expectations. Stories that address internal conflicts not only convey what happened but explore what it meant to the protagonist, resulting in a deeper understanding. Finally, philosophical conflict tackles the larger issues of human existence such as right/wrong, good/evil, or justice/injustice. A DST facilitator could use this basic taxonomy of conflict to help a participant convey not only what happened but what those events meant to them and how they might be connected with the bigger themes of human experience. A well-written DS will address all three levels of conflict in just 300–500 words.

There are many other creative writing tools and techniques that can help participants write their story, and DST facilitators can take advantage of the many available resources to further explore story structure and substance. However, when considering the creative writing aspect of DST facilitation, it is important to emphasize that literary talent matters, but the ability to recognize the stories in the lives of others is paramount. DST facilitators help participants connect the events of their lives in a way that provides movement and character development—transforming the chronological, technical account of their health experience into a story. If done effectively, this can result in a re-storying of a painful health experience into coherent, meaningful narratives that create forward momentum in the lives of both the participant and the audience.

**Crafting the Story: Conveying Emotional Experience**

I think with digital stories you’re just way more thoughtful . . . the images and the music allow for more of the emotion to come across . . . they allow you to feel things. Cause it’s difficult to express how you felt in a moment just off the top of your head. (Participant quote; Laing et al., 2017a)

Human emotions can be complex and hard to communicate (Angus & Greenberg, 2011) and the audio-visual nature of DST provides an opportunity to feel the emotional experience of the creator (Laing et al., 2017a, 2019; Lambert, 2013). This can be
accomplished by helping participants with the (a) selection of images; (b) pacing and timing; (c) cropping, movement, and overlays; (d) transitions; and (e) music. A basic video editing program, such as iMovie, Windows Movie Maker, or online video editing programs (e.g., WeVideo), will provide all the tools needed to create a visually powerful DS. The primary outcome of this phase of DST facilitation is to help the participant convey his or her inner emotional experience by thoughtfully co-crafting the DS. This phase, by its very nature, is personal and creative, and much of this section is based on the first author’s extensive experience in creating DS in a health care context, as published articles about these artistic aspects of DST facilitation are limited.

Selection of images. The use of images, both still and moving, is what allows complex health care stories, that address external, internal, and philosophical problems, to be shared in only 3 min. Visual metaphors, such as a melting ice cream cone to represent changing expectations, or a long, dark hospital hallway to represent a health care journey, can add meaning to a DS without writing on the nose (Laing et al., 2017a). Recurring imagery can be used to connect events, create tension, and/or visually represent character development. The color of an image also contributes profoundly to the emotion it generates, with black and white or dark tones enhancing a sense of sadness or dread and light, colorful tones communicating happiness and anticipation. Communicating emotion through words alone can be a complex and difficult cognitive process, and many individuals, particularly children and adolescents, lack the verbal skills to express themselves (Laing et al., 2017a). Image selection, therefore, can be an enlightening and therapeutic activity (Planalp, 1998). Many participants use personal photos from their past that are meaningful and often representative of complex life events. The very act of looking for and selecting these photos can enhance reflection and connection to important life events (Fryrear & Corbit, 1992). Some DST participants indicated that they did not know how they truly felt until they saw it represented visually (Laing et al., 2017a), and in this way, the images selected can allow for deep emotional communication.

Pacing and timing. The pacing of images—the rate at which they change on screen—is an effective way to create a feeling. In most films, a single shot is on screen for an average of 4–6 s (Bordwell, n.d.), and this pacing could provide a starting point for DST participants as well. Linger on a single image for longer than 6 s fosters a reflective, calm emotion while quick flashing of photos of less than a second each creates a tense, chaotic feeling. Similarly, timing images to end or appear at important moments in the narration or with a crescendo in music can emphasize a desired feeling. The use of a black screen is also a powerful, dramatic tool when employed at the right time.

Cropping, movement, and overlays. In addition to the timing and pacing of the images appearing on the screen, the speed of movement around the images while they are on screen can help tell the story or convey emotion. Cropping, moving images around the screen, and/or zooming in and out can create a more aesthetically pleasing composition, focus the audience’s attention on a specific area, or reveal new content. For example, zooming in toward the eyes can help the audience get to know a character in the story, while zooming out from a single face to a larger group can create a sense of community or connection. Finally, compositing images by altering the opacity of one image overlaying another can emphasize the interconnectedness of two events in a story or enhance an intended emotion (e.g., faint storm clouds overlaying another image to enhance a feeling of foreboding).

Transitions. The transitions between individual images can also help convey emotional intent and important story events. Rough, choppy transitions between images create a disjointed, abrupt sensation while smooth cross-dissolves and fades create a controlled, reflective sentiment. A slow fade between two images can create a sense of connection between them, while fading to or from a black screen can be used to separate different events and scenes within the story. Altering the style and length of transitions is perhaps not only a creative process but a reflective one as the DST facilitator works with the participant on what they want to convey.

Music. Music is the final possible element to enhance the emotional intent of a DS. A soft, lilting song can create a sentimental feeling while a thundering classical score can create a sense of drama or adventure. Modification of the music track may be required to fit the story length and effectively enhance the emotion at various moments in the story. It should be noted that in some instances, the absence of music and the presence of silence can be an evocative tool.

Inspiration can be drawn from many sources when crafting a DS. While it is endlessly creative, the goal is straightforward: the voice-over narrates the story, while the images, music, pacing, transitions, and effects allow the audience to feel what happened (Laing et al., 2017a). Crafting a DS provides a unique opportunity to explore the inner emotional experience and sets the stage for the feelings of empowerment and pride that can result from genuine audience engagement (Laing et al., 2017a, 2019).

Showing the Story: Affirmation Through Audience Engagement

I was feeling so lost... and then now I just kind of feel filled with... well... I, I think we often don’t realize that something simple and little like that can be so helpful. (Participant quote; Laing et al., 2017a)

An important piece of storytelling is having an audience to witnesses it (Frank, 2012; White & Epstein, 1990) and a potentially therapeutic aspect of DST is the affirmation inherent in
meaningful audience engagement with the DS. It is through audience engagement that some participants come to understand, often for the first time, that their story matters. Depending on the primary purpose of a DST project (education, advocacy, research, therapeutic intervention), providing participants with opportunities to share their DS privately with friends and family, or publicly, through facilitated screenings and/or online dissemination platforms, is an important final step of DST in a health care setting.

All participants are given a copy of their finished DS to use as they like. Many participants choose to share their story privately with friends and family, while others post their story to YouTube and share it publicly via social media. Regardless of the dissemination method chosen, the DST facilitator should sensitize the storyteller to the potential ramifications sharing their story and address any ethical issues that could arise. If the intended audience of a DS are health care professionals, the DS facilitator could help organize and facilitate a screening.

Debriefing a screening experience with the participant is an important final step. This discussion provides an opportunity to reflect on the DS experience and process the feedback provided by friends, family, strangers, or health care professionals who viewed the DS. One potentially important outcome of the debrief is affirmation of both the life lesson expressed in the story and the re-storied life experiences (White & Epston, 1990).

Discussion

DS in a health care setting can be used as tools for education and advocacy, as data in the research process, or as a therapeutic intervention, depending on the intent. DS can offer insight and understanding leading to changes in beliefs, attitudes, and values of health care professionals; they can be instrumental in generative practice change (AHS, 2019; Laing et al., 2017b; Price, Strodtman, Brough, Lonn, & Luo, 2015). If advocacy is the intended outcome, DS can be a powerful and compelling tool to influence public opinion and explain why the health-related issues being addressed matter to patients and their families (Cueva et al., 2016). In certain research contexts, DS can be a valuable data source that can cultivate a deeper understanding of health-related phenomena (De Vecchi et al., 2016; Wexler et al., 2013). Finally, DS can also be used as a psychosocial intervention when they are created with therapeutic intent as the primary goal. Regardless of the intended outcome(s), dedication to the participant’s well-being is an ethical imperative and vital for any successful DST project (Gubrium, Hill, & Flicker, 2013). The ethical implications of DST deserve more attention than can be provided in this article; however, utilizing a “continual consent” process (Gubrium et al., 2013; Laing et al., 2017a, 2019; Storycenter, n.d.), ensuring thorough and clear pre-project communication with potential storytellers, and consistently making decisions that put the storytellers' physical, emotional, and social well-being at the center of all phases will avoid most ethical pitfalls.

Two additional considerations of DST in a health care setting should be addressed: participant age and the structure of DST facilitation. In research studies of children and adolescents (5–17), YAs (18–39), and older adults (40+), it was noted that each age-group realizes different benefits from DST that generally mirror developmental life stage (Laing et al., 2017a, 2017b, 2019). Developing a sense of autonomy is a fundamental developmental activity of childhood (Chickering & Havighurst, 1981), and with pediatric oncology patients and survivors, DST can be an opportunity for them to determine their story; it can give them agency to choose the narrative of how cancer will impact them. In the YA population, identity formation is a fundamental activity (Arnett, 2000) and for them, DST offers an opportunity for them to define their story. By making sense of their cancer experiences in story form, they can begin to incorporate cancer into their identity in a salutogenic manner. For older adults, a fundamental developmental life task is to adjust to physiological changes and retirement (Havighurst & Albrecht, 1953). Opportunities to reflect on their life through the DST process can help with this adjustment by providing an opportunity to distill the lessons learned and wisdom gained throughout the years. A DST experience can be an opportunity for them to discover their story through the identification and exploration the major themes of their life (Laing et al., 2019).

Finally, there are many ways to structure DST programs. Some researchers worked one-to-one with participants over three 2-hr sessions, using Final Cut Pro X to edit the stories (Laing et al., 2017a, 2019). Other projects have used a group workshop format over 2 or 3 days (AHS, 2019; Davis, 2004; Lambert, 2013), while others allow participants to take iPads and work independently (Sitter, 2017). Ultimately, if all four phases of the DST process are completed, the format of a DST program can be modified to meet the unique needs and goals of each health care setting.

Limitations of DST in a Health Care Context

Health care research and practice is currently dominated by an objectivist, postpositive epistemology (Greenhalgh et al., 2016), and this can foster a reluctance to employing DST for several reasons. First, health care practitioners often value generalizable knowledge above all else, and this creates an environment where the value of a single person’s story to enhance understanding may be diminished (Moules, Venturato, Laing, & Field, 2017). Second, an objectivist epistemology is inherently suspicious of an individual’s objective memory recall (Crotty, 1998), which shifts the focus away from finding meaningful lessons in a story to a preoccupation with confirming if the events “actually” occurred in the way they were described. Finally, health care research and practice often has a homogenous, ethical framework in which blinded studies and fully de-identified data are the gold standard (Rodgers, 2005). Therefore, participants using their own voices and photos in a DS could be viewed as an ethical breach of confidentiality.

A response to these limitations is provided by exploring the purpose of DST in health care settings. The purpose of a DS is
not to generate generalizable and reliable knowledge; it is to
cultivate wisdom and understanding through reflection on the
deep, underlying themes that every health care story contains
(Laing et al., 2017b). Additionally, DS are not meant to be
objective representations of facts and events but rather a
glimpse into the inner emotional experience of the participant.
The credibility of a DS comes from the emotional authenticity
of the story versus the objective details of events or experiences
and, as such, opens up a role for memory and imagination as
legitimate informants into individual experience (Caine, Mur-
phy, Estefan, Clandinin, Steeves, & Huber, 2016). Finally,
there are established procedures to avoid potential ethical pit-
falls (Gubrium et al., 2013) as well as many examples of DST
research studies and programs that have successfully navigated
these challenges when working with vulnerable populations
(AHS, 2019; De Vecchi et al., 2016). It is the position of these
authors that a paradigm shift in health care is necessary to
appreciate the value of DST and not the modification of the
DST process or product to better fit the dominant paradigms of
the current health care environment.

Conclusion

...talent without craft is like fuel without an engine. It burns
wildly but accomplishes nothing. (McKee, 1997, p. 28)

McKee (1997) stated that “a culture cannot evolve without
honest, powerful storytelling” (p. 13). In the same way, DST in
health care will not advance the self-knowledge and narrative
coherence of participants, or uncover new insights in health
care research and practice, without an understanding of the four
basic phases described in this article. It is important to have
knowledge of the health phenomena being explored to see the
story and a deep understanding of the craft to help participants
tell it well (McKee, 2017). Understanding the concepts
described in this article is a first step toward a deeper under-
standing of the DST craft, but in itself, it is not enough to
prepare health care practitioners and researchers to facilitate
DST projects. There are many ethical and logistical nuances
that cannot be adequately addressed in writing, they must be
experienced. For this reason, it is suggested that researchers
and practitioners interested in this methodology search for
opportunities first participate and then co-facilitate DST pro-
jects with other experienced professionals to learn the craft
before pursuing their own projects. A dedication to learning
the craft of DST is important because we are always already
interpreting the world around us (Gadamer, 1966/2007), and
through the combination of words, images, and music, DS have
endless interpretive potential for both the audience and
the participant. Many participants talk about watching their DS
numerous times by themselves and with friends, family mem-
bers, and health care professionals, discovering new mean-
ings with each viewing (Laing et al., 2017a). Participants and audi-
ences can revisit these stories at many different times through-
out their lives, potentially learning something different every
time. In this way, a DST facilitator continues to help partici-
pants re-story their health care experiences and integrate those
experiences into their life in new ways, long after the project is
complete. Within the basic process of DST facilitation, there is
endless potential for creativity and adaptation, and for this
reason, the DST process described is simply a starting point
for many potential moments of understanding and diminished
suffering.

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ORCID iD

Michael Lang @ https://orcid.org/0000-0002-5738-7280

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