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Narrative Medicine: An Interdisciplinary Approach to Address Burnout Among the Nursing Workforce

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Abstract

Healthcare providers (HCPs) experience unprecedented burnout. During the COVID-19 pandemic, the healthcare workforce was pushed beyond its capacity, driving some out of the field, leaving hospitals and healthcare agencies to face unrelenting demand for care. Limited staff and resources challenged organizations to redesign infrastructure and processes to meet COVID-19 safety guidelines while balancing the priorities of finance and people.

Two years into the pandemic, the signs of burnout among nurses in an RN-BSN program surfaced, which paralleled the bitter resentment happening across the nursing profession. Nurses working on the front lines reported feelings of abandonment, lack of resources, staffing shortages, exhaustion, fatigue, hopelessness, and a sense that healthcare systems were falling short in caring for the caregivers. Similar to military service members who returned from combat, nurses project the workforce will experience considerable post-traumatic stress disorder after the pandemic.

Keywords: narrative medicine, reflective practice, nursing, burnout

REFLECTIVE WRITING AND NARRATIVE MEDICINE provide HCPs an opportunity to listen to a patient's story profoundly and to reflect on their personal feelings and experiences. Nurses and other HCPs find validation, hope, and healing through reflection and storytelling. In partnership with narrative medicine experts in the disciplines of Psychology and English, we hope to open the door to collaboration and storytelling among disciplines and shift the culture of health care to embrace vulnerability and openness as strengths in delivering patient care.

During the COVID-19 pandemic, the healthcare workforce was pushed beyond its capacity, driving some out of the field, leaving hospitals and healthcare agencies to face unrelenting demand for care. Limited staff and resources challenged organizations to redesign infrastructure and processes to meet COVID-19 safety guidelines while balancing the priorities of finances and people. The crisis in healthcare is especially pronounced in rural areas. All who touch the healthcare system—from patients to healthcare providers (HCPs)—are affected.

Cal Poly Humboldt's nursing program is a unique site where some of the most vexing issues facing healthcare today are the focus of classroom discussions and educational practice. Cal Poly Humboldt Nursing's RN-BSN program is designed for active working nurses to achieve a Bachelor of Science in nursing (BSN). Nurses come to the program with lived experience working in the field, many seeking new opportunities

and a chance to "breathe life into their career." The university nursing program has long been a fixture of our North Coast region and a site for grappling with broader healthcare needs.

For many years, Cal Poly Humboldt had a pre-licensure nursing program, where students could become a registered nurse and get a Bachelor of Science degree in nursing. In 2011, the pre-licensure nursing program was closed. Since that closure, the surrounding community and campus partners had been strategizing to create a nursing pathway at Cal Poly Humboldt. After years of planning, the university welcomed its first cohort of RN to BSN students in August of 2020. Although the world was experiencing a pandemic and the healthcare system was experiencing unprecedented amounts of stress, nurses continued to be resilient advocates for change for their patients and their profession.

As an integral part of the community, Cal Poly Humboldt has a renewed vision and purpose to address disparities across the healthcare system. As an Hispanic-Serving Institution (HSI) located on unceded Wiyot land and in close proximity to several Tribal communities including Hupa, Karuk, Mattole, Tolowa, Wailaki, and Yurok, it is the duty of Cal Poly Humboldt to continue to support students who want to serve their communities by addressing health disparities and healthcare needs. We serve our students and communities best when we prioritize the practices that honor their full humanity and their cultural diversity.

In order to address the mounting complexities of healthcare in a holistic and sustainable way, we propose reflective practice, informed by the principles of narrative medicine, as a response. We argue that reflective practice provides many benefits to the healthcare system; it not only improves the patient's experience and healthcare outcomes, but also the wellbeing of the HCP. Not only is it ethical, humane, and wellbeing-oriented to engage in this reflective work, it teaches HCPs how to practice vulnerability and communicate with patients. In essence, it is a pragmatic approach for improving healthcare outcomes, increasing efficiency, and supporting HCPs' own wellbeing and longevity in their careers. This meets the need for a more compre-

hensive education for HCPs—a biopsychosocial education is incomplete without reflective practice.

In what follows we identify reflective practice as an integral part of nursing education. We begin by naming the central challenges that nurses, and healthcare practitioners more broadly, face and how these have been exacerbated in a time of global crisis. We articulate the need for systemic change within healthcare and locate the role reflective practice can play in realizing widespread transformation. In particular, reflective practice may be a key means of preventing healthcare worker burnout. Drawing upon interdisciplinary scholarship, we offer a theory of reflective practice that is informed by principles of narrative medicine. We then further elaborate how the programs at Cal Poly Humboldt apply these principles in pedagogical settings—in the nursing program and in other programs within the School of Applied Health. We see the work of writing this article as itself an opportunity to enact reflective practice, as we articulate the principles that guide the nursing program's response to community and professional needs. We see this work as grounded within the Scholarship of Teaching and Learning (SoTL) as this is a self-study and an opportunity to be in conversation about the teaching and learning practices we foster in the nursing program.

Compounding Issues within the Healthcare Setting

The COVID-19 pandemic highlighted the complex issues present within the healthcare systems and nursing profession. Although this paper will focus on HCPs in a larger context, it is important to understand the dynamic of nursing as it has been and continues to be the largest section of the healthcare professions (American Association of Colleges of Nursing 2019). Many of these issues have been present since the inception of the nursing profession but are rarely discussed or researched. The image of the nursing profession has always been positive, focusing on the caring and trusting nature of nurses. For decades, society has ranked nursing as one of the most trusted and ethical professions (Saad 2022). However, despite these positive at-

tributes, there have been increasingly challenging issues for nurses. Issues of increased work demands, lack of power/support, increased moral distress within and outside of the healthcare system, and a pervasive nursing shortage have been common themes within the nursing profession even without the additional stress of a global pandemic (Davidson et al. 2020; Haddad, Annamaraju, and Toney-Butler 2022). Nurses provide the best care possible, sometimes at the expense of their physical and mental health.

Within a healing profession, there is ubiquitous pressure on HCPs to be the epitome of health and wellness. At the same time, HCPs have often been asked to disregard their own psychosocial identities and needs (e.g., emotional, cultural, spiritual, economical, psychological) in order to more effectively address the biomedical needs of the patient. As medical doctors and faculty members of Columbia's Narrative Medicine program, DasGupta and Hurst posit that when HCPs openly grapple with personal illness (whether physical or psychological), it is often seen as threatening "the integrity of the club" and "is tantamount to treachery" to the "fraternity of healers" (DasGupta and Hurst 2007:3). Such are the pressures placed upon HCPs who deal with high levels of stress and grief, but with an imperative to not allow these forms of stress to become evident. The pressures on HCPs—and the imperatives to perform in ways that deny one's own body and mental health needs—are untenable.

As the human experience ebbs and flows, a HCP's mental health can also ebb and flow. In a workplace environment where stress and grief are regularly present, HCPs are faced with an impossible task of keeping their composure. During their shift, HCPs maintain their composure so that they are able to take care of the next patient, but what happens when HCPs go home? How does one cope with not wanting to take work home when home is the only place where one has adequate space to process the day? How does one share their experience while maintaining confidentiality? These are all questions that HCPs face. The task of processing the human experience often becomes overwhelming and can lead to physical and mental manifestations.

Healthcare providers are exposed to repeated trauma, yet are not provided with the tools and space to process emotionally challenging events. As health psychologist Nicola Davies (2021:n.p.) writes, "Many nurses agree that nurse training doesn't adequately equip them with the skills needed to cope with grief" and that "there is a discernible lack of safe spaces in healthcare institutions where nurses feel able to examine their emotions." During reflective group work within nursing populations, we have heard similar reports. One practicing nurse in the Cal Poly Humboldt nursing program, for example, reported that during the transition at the end of a shift, all the biomedical information is passed along to the next team, but no time is allotted to discuss the emotional aspects of the day. This, they noted, is particularly challenging when a patient has been abusive or passed away: there is no opportunity to process the event. The lack of psychosocial support can carry serious ramifications for HCPs.

One such ramification is addiction. Without healthy outlets for addressing the challenging emotions associated with regular exposure to trauma, it is easy for HCPs to turn toward numbing agents in order to self-medicate and cope. For instance, in working with emergency medical technicians (EMT) responders in reflective writing groups, it is common to hear reports of going out to drink after every shift. To illustrate, after sharing with the group a story involving the death of a two-year old boy, an EMT participant shared, "I think everyone wanted to cry, but crying isn't okay, so we got hammered after work and made horrible jokes in some kind of attempt to not feel it." The challenge, he noted, was knowing this was not healthy but feeling unable to cope with it differently because "it's just how it works in this profession." Speaking to this, Monroe and Kenaga (2011:1) note that instances of addiction within the nursing field are estimated to be as high as 20%, yet a culture of silence and fear of punishment often prevent nurses from seeking help. Furthermore, the easy access to prescription medication in healthcare contexts only exacerbates the risk. While substances may provide temporary relief, they are no substitute for processing challenging experiences.

When HCPs experience mental health issues themselves, they often turn inward due to fear of stigmatization; yet, ironically, if a patient had mental health issues,

the HCP would help that person navigate to support and resources. According to HCP researchers Davidson et al. (2020), the U.S. had already seen increasing rates of suicide among HCPs before the pandemic. They recognized the toll of these stressors and conducted the first longitudinal study to examine the complexities of nurse suicide in the U.S. from 2005 to 2016. They found that compared to the general population, nurses were not only at a greater risk of suicide, as previous researchers had shown, but nurses completed suicide at a higher rate than the general population. Comparatively, nurses were also more likely to have a mental health history and issues within the workplace (Davidson et al. 2020). In addition, nurses might delay mental health care due to workplace and professional stigma (Knaak, Mantler, and Szeto 2017; Gilligan 2021). The stigma is perpetuated by workplace and professional cultures that portray HCPs who need mental health care as people who are unable to work in a high stress environment (Knaak et al. 2017). Given the immense amount of stress that HCPs experience, there is a reluctance to discuss mental health concerns, which can lead to isolation, reliance on other coping mechanisms (e.g. self-medicating), and burnout (Knaak et al. 2017).

Two years into the pandemic, the signs of burnout among nurses have surfaced with increasing frequency and bitter resentment. Nurses working on the front lines reported feelings of abandonment, lack of resources, staffing shortages, exhaustion, fatigue, hopelessness, and a sense that healthcare systems were falling short in caring for the caregivers. The increased stress and unaddressed mental healthcare crises from the COVID-19 are projected to exacerbate mental health issues and suicide rates among healthcare workers (Awan et al. 2022).

The influence of the workplace environment on a HCP's experience, both as a provider and as an employee, cannot be overlooked, especially as retention of the healthcare workforce is even more imperative in times of ongoing public health crisis. In a systematic review, Yahyaei et al. (2022) examined factors within the workplace environment and nurses' intention to stay within that organization. One of the main elements that increased nurses' intention to stay was organizational support and nursing empowerment (Yahyaei et al. 2022).

The importance of nursing empowerment has been a key component of the nursing profession both historically and currently (Kagan 2006). JoAnn Ashley, a nursing scholar and advocate, defined power in nursing as being composed of awareness, freedom, choice, action, and creativity (Kagan 2006). Ashley was also aware of the complex relationships between the nursing profession, other healthcare professions, society, and the healthcare system. They are separate but overlapping entities that must allow for intrinsic growth separately and together, all while grounded in humanistic principles (Kagan 2006). Yahyaei et al. (2022) focused on nurses' intention to stay within an organization, rather than the profession. Yet in rural areas with a lack of nurses and healthcare organizations, nurses have limited options when their workplace environments are not supportive. Organizations have limited access to qualified applicants when nurses leave the organization or the profession. From bedside nurses to administrators, the cyclical turnover of nurses negatively impacts the entire healthcare system.

Education Toward a Culture of Caring in Institutions of Health

Systemic change in healthcare settings may start with the reflective practice of the individual. Nurses report nursing school does not adequately prepare them for the emotional demands, complexities of patient care, and human factors they face in practice. As such, most nursing programs do not integrate self-care strategies to manage compassion fatigue, the demands of working in complex settings, and working with multiple providers and disciplines (Horton-Deutsch and Sherwood 2017). Transforming healthcare systems requires a shift in education that includes innovative practice that fosters human caring. Jean Watson's theory of human caring offers a framework for teaching and learning as a caring encounter, "embracing the belief that trust and faith in human expression and self-actualization is the focus of the educational process" (Hills and Watson 2011:218). The premise of Watson's caring science model is caring for self to care for others. Reflective practice shifts the paradigm of traditional nursing education from a lecturing model to a learner centered education that honors

and leverages the experience of the individual to foster professional growth and development (Horton-Deutsch and Sherwood 2017). Through transformational practice nurses reflect and apply learning, thus developing multiple ways of knowing beyond empirical knowledge that includes aesthetic, legal, ethical, and personal knowledge (Horton-Deutsch and Sherwood 2017). The scholarship of teaching and learning within healthcare disciplines can continue to realize the promise of these educational shifts, as healthcare pedagogy continues to respond to the pressing needs of the practitioners we serve in the health disciplines.

Healthcare Worker Burnout

Compassion is core to nursing practice and is defined by the American Nurses Association Code of Ethics as "An awareness of human suffering, tempered with reason, coupled with a desire to relieve the suffering; a virtue combining empathy, benevolence, caring, and mercy. Used with the cognitive and psychomotor skills of healing to meet the patient's needs" (ANA 2015:41). Unfortunately, when nurses face continuous trauma without adequate support, they may be exposed to secondary traumatic stress resulting in feelings of despair that contribute to physical symptoms including anxiety, sleeplessness, lack of job satisfaction, nausea, and depression (Schmidt and Haglund 2017). Ultimately, without intervention, these symptoms can lead to burnout (sometimes referred to as "compassion fatigue"). Burnout, as physicians Gregory Nolan and colleagues note, can be "characterized by depersonalization, emotional exhaustion, and low personal accomplishment" and result in "decreased productivity, depression and suicidal ideation, impaired professionalism and communication, and professional errors and near misses" (2020:184). We have also heard HCPs describe burnout as apathy, disillusionment, and even anger with patients.

Traditionally, it has been suggested that the best method for avoiding burnout and establishing professionalism is to maintain emotional detachment from both patients and self. Yet, research increasingly supports that the practice of "self-reflection and the ability to constructively process emotions" serve to protect against stress and burnout (Guillemin and Gillam 2015:727). Put simply, the practice of detaching from emotional engagement is not the safeguard it once was thought to be. In fact, it can serve to generate a range of serious threats to HCPs' wellbeing. For instance, when HCPs' emotional lives and reflections on their workplace experiences are seen as irrelevant or even inappropriate to the work they perform, it can create social alienation and disillusionment. Kinman et al. (2016:8) describe these types of psychosocial ramifications involved in nursing labor and call for "social support" in which there are "opportunities for staff to create space for reflection, discuss emotional reactions to practice, and reaffirm core nursing values." Doing so, they argue, will help "protect against social alienation and burnout" through the development of "social connectedness" (2016:8).

Put simply, the cause of HCP burnout is a result of multifaceted systemic dysfunction causing a cascade of negative outcomes on the overall health of the population and the wellbeing of those who care for them. The U.S. Surgeon General, who names lack of a space for vulnerability as a factor contributing to burnout, has established addressing HCP burnout as a national priority (U.S. Department of Health and Human Services 2022). These issues within the healthcare system are intersectional. Certain positions within the healthcare sector employ higher numbers of women and people of color—people who find the challenges of healthcare service compounded by racism, classism, sexism, and a historical lack of power. These issues are not only present within the healthcare system and society but within healthcare organizations and workplace cultures. There is an urgent need to create work environments that foster a culture of collaboration and vulnerability and allow for individuals to have their voice heard.

Reflective Practice as a Response

As a response to these difficult circumstances facing HCPs, including those of the students who come to Cal Poly Humboldt's newly formed School of Applied Health, we seek to equip students with the skills of resilience, self-acknowledgement, and self-care that are cultivated in reflective practice. We take this orientation with

the research-informed perspective that reflection is both good for HCPs and good for their patients. Reflective practice is therefore the center of our pedagogy.

Boud, Keogh, and Walker (1999) define reflective practice as "those intellectual and affective activities in which individuals engage to explore their experiences in order to lead to a new understanding and appreciation" Drawing from their definition, by "reflective practice" we mean an orientation and way-of-being that guides one's decision-making and supports one's resilience in each encounter. In other words, reflective practice is more than a simple skill-set; instead, it might be thought of as a deliberate disposition or habit-of-mind that translates into one's day-to-day communications, attitudes, and choices.

To elaborate, reflection provides the metacognitive possibility of making one's interiorized thought-life less automatic and more available for consideration and, in turn, revision. Reflection allows for re-evaluation and the potential to change one's patterns. For these reasons, reflective practice is associated with a growth mindset that orients toward learning—finding the opportunities available in challenging and changing circumstances. Speaking to this, Lutz et al. (2013:343) found that their reflective practice pedagogy enabled students to "come to see difficult professional situations as challenging yet manageable learning experiences, thus leading to the personal outcome of a sense of improved attitudes and skills for the management of difficult personal and interpersonal situations and reduced stress."

Reflective practice is thought to cultivate resilience; challenges are met with flexibility, responsiveness, and an ability to adapt. This orientation also requires a degree of detachment; difficult circumstances are expected and met with confidence, and difficulty is not judged as "bad" or as a reflection on the self. A reflective practice refuses self-judgment or fixed labeling, but instead seeks to better attune to the situation as-is, in order to serve the needs (of self and other) in a given circumstance. In this sense, reflective practice is related to mindfulness—the cultivation of nonjudgmental awareness—which has been shown to have positive effects for wellbeing. Research on the effectiveness of mindfulness based stress reduction (MBSR) continues to proliferate

within the healthcare sector (van der Riet, Levett-Jones, and Aquino-Russell 2018; Gautam, Palaniveu, and Kaur 2020; ElKayal and Metwaly 2022; Wexler and Schellinger 2022). It is for these reasons that we turn to reflective practice as a way-of-being, one that can support the HCP who navigates the adverse circumstances of today's healthcare system.

Reflection is a deliberate practice and continually cultivated skill, rather than an assumed human quality. In a longitudinal study of 117 medical students, Park et al. (2022: 1) found that "[s]elf-reflective ability is not naturally developed as students' progress through grade levels." They recommend: "Educational intervention is needed to help students understand approaches to self-reflection and its importance in enabling them to develop their abilities as well as to participate actively in reflective writing" (1).

There are many pedagogies of reflection utilized in health-related professional training. For example, Lutz et al. (2018) used clinical reflection training (CRT) which focuses on experiential learning centered on the professional dilemmas faced by medical students. The features of a CRT pedagogy are a focus on current and real problems; an experienced and supportive trainer; a supportive group with whom reflection could be processed in dialogue; and a secure space for reflection. The pedagogy invites students to observe their bodies, their emotions, and their mental models with curiosity and non-attachment. Lutz et al. (2018) report that participants experienced stress reduction and reported improved quality of patient care as a result of the reflective practice pedagogy.

Reflective practice informed by the principles of narrative medicine

Within medical education, reflective practice has been cultivated through the research and application of narrative medicine or narrative-based medicine. Narrative medicine is a field that cultivates a set of skills and experiences for both patients and HCPs, seeking to make healthcare more humane, empowering, and beneficial for all.

As Rita Charon (2017:1) explains, "Narrative medicine began as a rigorous intellectual and clinical

discipline to fortify healthcare with the capacity to skill-fully receive the accounts persons give of themselves—to recognize, absorb, interpret, and be moved into action by the stories of others." Charon, an MD and PhD in literature, is most often attributed as founding and solidifying the field of narrative medicine in the mid-nineties. She writes of the emergence of the field, from her seminal work *Narrative Medicine: Honoring the Stories of Illness* (2008: vii): "The field of narrative medicine has emerged gradually from a confluence of sources—humanities and medicine, primary care med-icine, contemporary narratology, and the study of effec-tive doctor-patient relationships." She argues that the value of narrative medicine is that it "provides health care professionals with practical wisdom in compre-hending what patients endure in illness and what they themselves undergo in the care of the sick." The field has burgeoned to include many sub-areas, including practices that enable better patient-provider relation-ships, more ethical orientations, career longevity and wellbeing for healthcare workers.

Although its influence continues to grow, narra-tive medicine is primarily associated with the medical humanities, a disciplinary home for multiple forms of scholarship and practice that explore the ethical, his-torical, literary, creative, anthropological, philosophical, and religious dimensions of medicine or health. The medical humanities are guided by the recognition that medical practice always involves interpersonal commu-nication, interpretation, ethics, empathic orientations, and humanistic understanding.

Narrative medicine is, in Sayantani DasGupta (2022:n.p.) words, "the clinical and scholarly endeavor to honor the role of story in the healing relationship." The field understands story as permeating every part of the clinical encounter—from how a patient tells of their symptoms to how HCPs tell the story of treatment and prognosis.

Story can also be a deliberately utilized tool for stress reduction, reflection, and coping for both patients and HCPs. Reflective writing has an important role in narrative medicine and opportunities to engage in it have proliferated throughout a broad range of health-care contexts, including hospitals and higher education.

In what follows, we demonstrate how reflective practice, informed by the principles of narrative medi-cine, supports the HCP's ability to attune to the stories occurring in the clinical setting, enabling providers to become better able to treat patients with accuracy and care. At the same time, reflective practice also supports HCPs' own wellbeing. Reflective writing is one avenue for engaging with a reflective practice, and it can sup-port self-understanding, acceptance, growth, and resil-ience in the face of the challenging circumstances every HCP encounters.

Reflective practice and narrative medicine in the clinical setting: toward patient-centered care

Medical practice is always mediated by inter-pretation and story. The patient tells the story of their symptoms, their background, their cultural orientation to treatment; this story is interpreted and acted upon by the HCP. In turn, the HCP tells a story of diagno-sis—which is a story that imagines the past, present, and future of a disease or condition. As Lewis Mehl-Madro-na (2007:83) notes, in clinical settings, we are always co-creating the story: "We are co-creating a shared story of healers and patients/families/communities wherever we go. We are immersed in the art of storytelling." It is imperative that the HCP be able to listen to the pa-tient's story and to reflect on their interpretation of the story, questioning assumptions and seeking greater un-derstanding.

This type of reflection requires humility, a point emphasized by Melanie Tervalon and Jann Mur-ray-García (1998) in their scholarship and training on cultural humility. Noting the "sociocultural mismatch-es" that occur between patients and HCPs, along with the systemic prevalence and internalized biases of rac-ism, classism, homophobia, and sexism, Tervalon and Murray-García (1998) called for an intervention and reorientation in how HCPs approach clinical communi-cations. Their work undoes medical paternalism as Ter-valon and Murray-García call upon HCPs to commit to patient-centered care that prioritizes the agency, cultural orientations, and needs of the people whom healthcare is meant to serve. Cultural humility is a reflective practice

as it requires, in Tervalon and Murray-Garcías' words (1998:123), "a lifelong commitment to self-evaluation and critique, to redressing the power imbalances in the patient dynamic, and to developing mutually beneficial and non-paternalistic partnerships with communities on behalf of individuals and defined populations".

Building upon Tervalon and Murray-García's work, a specifically *narrative* humility has also been theorized by Sayantani DasGupta, drawing upon her background in narrative medicine. With the term "narrative humility," DasGupta emphasizes several forms of recognition that HCPs should practice in the clinical encounter. Specifically, the recognition that our patients' stories and their health conditions "are not objects that we can comprehend or master, but rather dynamic entities that we can approach and engage with"; respect for complexity, ambiguity, contingency, and contradiction as always present in the human condition; readiness to creatively co-create knowledge and meaning in the clinical space through acknowledgment of multiple perspectives and the authorization of the patient's knowledge and decision-making; and prioritization of self-evaluation and self-critique about our roles, expectations, responsibilities, attachments, identifications, and limits in any given situation. Narrative humility includes the moment-by-moment self-questioning: What/who am I valuing or prioritizing? What am I assuming or believing to be true?

A reflective and humble orientation counters several assumptions within medical practice: 1) the false assumption that medicine is only about finding the answers to scientific questions and "solving" healthcare conditions; it is not about people's identities, emotions, cultures, and relationships; 2) the false assumption that the treatment plan should be developed solely by the doctor without patient input and consultation; and 3) the false assumption that the provider is the sole expert and knows best on behalf of the other. In other words, narrative humility seeks to counter the institutionalized medical paternalism that has done much harm within the medical system.

Because of its demonstrated outcomes, reflective practice, as the cornerstone of narrative medicine, is a skill that is promoted across many medical education programs. Daryazadeh et al. (2020) conducted a quasi-experimental study of 135 medical interns and found that those who received narrative-based education increased their reflective capacities beyond those of the control group. With the addition of seven two-hour reflective practice sessions, a significant difference emerged in participants' scores on the Reflection Evaluation for Learners' Enhanced Competencies Tool (REFLECT) rubric (Daryazadeh et al. 2020).

George Zaharias (2018) notes that narrative practice "is intrinsically therapeutic for the patient (in the telling and in being listened to)." The skillset of close listening cultivated in the literary classroom, for instance, translates to the close listening needed to recognize that, in the words of Melanie Gregg (2020:n.p.), "Patients are not their symptoms… They are whole human beings with entire life experiences. Having the ability to listen with empathy and interpret and pull meaning from it is how a caregiver can lead a patient out of suffering and into a path of healing."

Healthcare providers who take a narrative medicine approach may use a number of techniques to enable "close reading" and "close listening" of patients' stories. One such technique is the composing and sharing of "parallel charts." A parallel chart is a log of writing reflections that give a window into the psychosocial thoughts and feelings arising during patient interactions. While such records are not conventionally found in medical charts, they nonetheless can inform skillful care. The patient may also be supported by sharing selections of this writing within a small group of peers (Charon 2006:156). Parallel charts may take any number of forms; the emphasis is not on a particular length or form, but instead on the regularity of the writing, as a tool for supporting the ongoing communication between patient and HCP and the opportunity for self-reflection from both participants in the medical relationship.

To provide an illustration, Matt (co-author of the present text) worked with a young social work student who had an internship at an addiction recovery center. Though she liked the work, she found herself particularly uncomfortable with one of the residents. It was not until she sat down and wrote her parallel chart that she realized the man reminded her of one of her mother's abusive boyfriends from her childhood. In this case, her parallel chart revealed an inherent bias previously not

recognized. As a result, her reflection alleviated some guilt she had been experiencing for her feelings and, as a result, allowed her to process her interactions with the man more mindfully. Often cited as the most meaningful part of the process, part two of her parallel chart process was to read it aloud to a group of peers. It is crucial to note that she was not required to do so ("passing" is always an option) and the feedback she received from other group members was limited to supportive expressions of gratitude and/or questions grounded in curiosity. This is *not* a space for giving advice, comfort, or critique. It is, rather, a space to listen and be heard and to bear witness to each other's experiences. It is a space to grow personally and professionally through reflection.

The "illness narrative" is another genre that promotes reflective practice through writing—one that has been used by narrative medicine practitioners Sayantani DasGupta and Rita Charon (2006) of Columbia University's Medical Center. Common goals of this practice are to: 1) situate participants in a patient's perspective through the practice of vulnerability; 2) develop trust in teammates while practicing compassionate communication; and 3) explore one's own relationship with illness and health in order to move against the biomedical tradition of silencing healthcare provider's biopsychosocial realities.

Matt has engaged illness narratives in medical education settings (Zytkoskee 2020:178), using this genre to support HCPs in reflecting on their own identity within the field. By gaining a better sense of who they are as professionals, why they entered the field, and why they are thinking, feeling, and behaving in certain ways, they are more likely to thrive. Illness narratives give providers an opportunity to reflect on the times when they have been in the role of patient within a healthcare setting, or when they have been the witness to another patient's experience from a position of family member or loved one, rather than the HCP. Such reflection cultivates empathy for the patient as it also fosters self-understanding.

Matt's experience working with HCPs included a multi-step process that models a common way of scaffolding provider engagement with narrative medicine approaches. First, participants come to an orientation session in which they ask questions and discuss example illness narratives that are provided ahead of time. Then they begin the writing process through brainstorming activities such as freewriting (writing non-stop for short periods of time), listing, and sensory description (reflecting on an experience through the lens of all five senses). Following this introductory session, participants independently write their illness narratives, which are defined as accounts of illness/injury they have experienced directly or by someone with whom they had a personal relationship. The primary guideline is that narratives must be about how the experience affected the participant personally. Once the narratives are completed, participants meet in small groups of four to ten and read their narratives aloud. With any group-sharing process within a narrative medicine framework, feedback should be limited to supportive comments and/or questions grounded in curiosity (e.g. "How old were you when this happened?"). It is important to remember that, while the texts produced are likely to be rhetorically powerful, the setting is not a creative writing class focused on an end product. Rather, it is about the benefits the act of writing has for the writer (Yagelski 2009:9). When reflective writers are given the opportunity to connect and share their writing with peers in meaningful, safe contexts, it can help them "develop the capacity for empathetic listening" and gain "significant insight" into "shared humanity" (Sierpina 2007:628). In essence, both the act of writing and the sharing of that writing carry significant potential for individual and collective growth.

Reflective practice and The Center for Mind-Body Medicine training in the clinical setting: toward HCP wellbeing

Another framework for the development of reflective practices is found in the Center for Mind-Body Medicine's (CMBM) evidence-based curriculum. CMBM was founded by Georgetown Medical School psychiatrist and former Chairman of the White House Commission on Complementary and Alternative Medicine Policy, James S. Gordon (2009). It focuses on self-care, social support, and community building in a broad range of populations and ages. Mind-Body Skills Groups, which espouse the mission of "teaching

thousands to heal millions" (CMBM 2023), focus on teaching participants practices grounded in meditation, reflective writing, drawing, guided imagery, autogenics, biofeedback therapy, mindful eating, mindful movement, and genograms (category-focused family trees). Research supports the efficacy of these groups (Maclaughlin et al. 2011; Greeson, Toohey, and Pearce 2015). Healthcare professionals experience significant declines in emotional exhaustion, depersonalization, and secondary traumatic stress, and improvements in sense of personal accomplishment and satisfaction with work (Weinlander, Gaza, and Winget 2020). A particularly appealing aspect of their approach to self-care and wellbeing is found in its straight-forward and pragmatic nature—the skills, once learned within a group setting, are easily practiced alone. To briefly illustrate, we will now outline two practices taught within CMBM groups.

To begin, CMBM offers a skill they term, "The Wise Guide," a guided imagery practice designed to help the HCP establish a safe psychological space for processing human experiences and accessing inner knowledge (Gordon 2009:117). Typically, this technique is facilitated within a mind-body skills group but, as noted before, may be practiced independently once an understanding of the process is rooted. It begins with a concentrative meditation technique, "soft belly breathing," which activates the parasympathetic nervous system (Gordon 2009:44). Next, participants are guided through a visualization of an internal "safe place," a place where they may find peace and reassurance even when facing trauma—whether past or present (Gordon 2009:114). Once the participant is settled in this internal safe zone, they are invited to "meet their wise guide." What this wise guide represents depends entirely upon the individual, with concepts ranging from a spiritual manifestation, a higher power, a collective consciousness, the imagined wisdom of someone in one's life, or a manifestation of one's own unconscious wisdom. Once the wise guide arrives, it is time to ask it questions regarding life circumstances, experiences, and trajectories. If responses are confusing, participants ask for clarification and accept that "words, images, sounds, feelings, impressions" all potentially hold answers (Gordon 2009:119). This dialogue is where processing takes

place, with many participants reporting that they received answers and insights they had not expected. The process lasts for roughly twenty minutes. After participants are gently guided back to group consciousness, they are given twenty minutes to write reflectively and/or share their experiences as a way to retain and process.

Another reflective practice taught within CMBM's Mind-Body Skills groups is the use of drawing as an outlet for self-expression, self-reflection, and an avenue for accessing the subconscious in order to find self-awareness and healing. LaPenna and Tariman note that art therapy is "an integrative mental health intervention involving creative processes, application of psychological theories, and human experiences within a psychotherapeutic relationship," and has an extensive history in the treatment of trauma with results demonstrating improvement in patient anxiety, depression, and overall quality of life (Gordon 2009). Supported by research on the efficacy of art therapy to improve both psychological and physical trauma (Kaimal, Ray, and Muniz 2016; Hass-Cohen et al. 2019; Betensky 1995; Broadbent et al. 2018), CMBM's approach employs drawing in the first and last sessions of their eight-week curriculum. In session one, they give participants roughly five minutes per drawing to complete three drawings with brief directions between each one encouraging participants to let the drawings manifest uncensored and quickly in order to be "authentic, surprising, revealing" (Gordon 2019:61). The prompts, which are designed to guide exploration of one's psychosocial realities, obstacles, and trajectories include: 1) draw yourself as you are now; 2) draw yourself with your biggest problem, challenge or issue; and 3) draw yourself with your biggest problem, challenge or issue solved (Gordon 2019:62-63). Once all three drawings are complete, individuals briefly present each drawing to the group and describe any sights, thoughts, and/or emotions related to the drawings and the experience of creating them. Facilitators are trained to guide this process through questions intended to help participants explore the experience at a deeper level (if needed). Analysis and critique are not part of the process other than by the participants themselves. Ultimately, the goal is that participants emerge from this reflective experience with a greater understanding of their

psychosocial realities and how they would like to guide their lives moving forward.

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**Reflection as a Way to
Humanize Nursing Educaion at
Cal Poly Humboldt**

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The current Cal Poly Humboldt nursing program launched in 2020 with a cohort of thirteen students. The courses are taught mostly online to support flexibility for working nurses. Students and faculty come together face-to-face twice a semester for weekend intensives. These weekends provide students with an immersive community building and learning experience. Through presentations and workshops from the faculty, community, national experts, and each other, they learn about topics related to their courses. The intensives also provide a forum to analyze the complex issues they face in serving diverse populations. These conversations encourage them to evaluate system-wide challenges and disparities and envision the healthcare system they want to create.

An innovative approach to strengthen bonds among Cal Poly Humboldt nurses

Given our rural regional context, Cal Poly Humboldt has a responsibility to address healthcare needs across multiple dimensions in a primarily online learning environment. Challenges with online learning include potential feelings of isolation among students. Cal Poly Humboldt's nursing program is intentional about creating a humanized approach to online learning. The program is mostly asynchronous, with two face-to-face weekend intensives each semester. We integrate reflective writing within discussion boards that includes student analyses and written and video reflections on the stories from their peers. The weekend intensives are also key to this goal. During year-one, the height of the pandemic, all the intensives were held synchronously online via Zoom. The bonds between students were strengthened through real-time interactions with each other. Since then, we have shifted weekend intensives to originally envisioned face-to-face experiences.

Fostering vulnerability through Narrative Medicine workshops

A program feature is designated time for writing and reflection that allows nursing students to process experiences in their workplaces. During these writing workshops, nursing students have shared how rare and important these opportunities are. One practicing nurse in the Cal Poly Humboldt nursing program, for example, reported that during the transition at the end of a shift, all the biomedical information is passed along to the next team, but no time is allotted to discuss the emotional aspects of the day. This, they noted, is particularly challenging when a patient has been abusive or passed away: there is no opportunity to process the event. The lack of psychosocial support can carry serious ramifications for HCPs.

During intensives, students attend narrative medicine workshops where they are invited to participate in reflective writing exercises. A short story exercise, for example, is designed to encapsulate key experiences of HCPs (Fogarty 2009). Students were asked to reflect on and write down a list of impactful illness/injury/trauma they had experienced. Through a series of brief free writing activities, they then identified words and emotions that were important to relating the experiences. Finally, they edited the writing down to a fifty-five word story. Students then shared their story with a peer in an online breakout room. Some students shared deeply personal experiences they had with patients and ill family members. This exercise created space for students to be vulnerable with their peers while having an expert in the field to help facilitate and debrief afterwards. Through this type reflective dialogue, both online and in person, students report feeling a sense of community in knowing they are not alone in feeling overwhelmed and stressed out by school, work, and family.

Reflective pedagogy in the nursing program at Cal Poly Humboldt

The start of 2020 began with the International Year of the Nurse to honor the 200th birthday of Florence Nightingale, the mother of nursing. This was a year

to honor the physically, emotionally, and intellectually challenging work that nurses endure to care for their clients. This worldwide recognition coincided with the COVID-19 pandemic, shining a spotlight on the essential role of nurses at the cost of unrelenting physical and emotional stress. By reframing experiences through CARING values,[1] students are able to contextualize their day-to-day experiences through analysis and reflection. The design of the virtual classroom and practical learning experiences are grounded in a humanized approach to foster community, connection, and innovation.

The COVID-19 pandemic forced educators to rethink the way they teach and the way they engage their students. Disruptive innovation inspired nursing program faculty to embrace online tools and resources in designing the new program curriculum and modes of delivery. The virtual classroom and practical learning experiences fostered inquiry and empowerment relevant to each student's nursing practice. In developing the first courses, the nursing faculty promoted a culture of caring while acknowledging the experience of frontline nursing students in the pandemic. The faculty designed cohesive learning environments where nursing students reflected on their lived experiences as nurses. Students leveraged new skills to foster inquiry and empowerment in their work in real time and with future-focused goals. Our nursing courses continue to have asynchronous and synchronous sessions to allow flexibility for working nurses. In order to foster a supportive class culture in a hybrid format, nursing students create written analyses and spoken reflections of their lived experiences.

In the first semester of the nursing program, students work on a reflective paper where they think about how people experience illness and the dynamic of power (or powerlessness) of nurses within the healthcare system. Students read seminal articles by Rita Charon (2009) and Paula Kagan (2006), as well as stories from patients with a chronic illness. Students then reflect on the role of the nurse and their own expectations of patients, their families, and HCPs. Shortly after submitting this paper, the students participate in a writing session facilitated by an interdisciplinary colleague. Although the incoming co-

hort completes the paper, the reflective writing session is conducted with both the incoming and continuing cohorts. The continuing students are included in the reflective writing session to encourage the adoption of reflective practice within their day-to-day nursing practice. Reflective writing is also built into each of the courses and discussion boards assignments.

One such example was a discussion board assignment focused on strategies for success to prevent burnout. Students wrote about their preferred communication style and how they could address burnout on a personal and professional level. Students then recorded a spoken reflection about the art of nursing and how they would nurture self-care during the nursing program and beyond. By recognizing communication styles and burnout rates, students are able to express their experiences on a personal and professional level to grow into more holistic, nurturing providers. One of the students shared: "It's kinda like therapy for all of us to come together and talk about these stressful experiences we have as nurses." Through reflection, students are able to honor the full spectrum of emotions that do not have a predetermined path, from catharsis to doubt. Students are able to learn the language and skills to process emotions as there is often a cascading effect. The emotional journey might prompt students to ask questions about themselves and their processing. A common question for HCPs is: "if I leave my emotions at the door, does it make me a bad person?"

Another way that the nursing program is fostering reflective practice is with virtual reality. Students experience nursing simulations to practice skills without the risk of adverse outcomes to a real patient. Although nursing education has adopted various innovative practices over the years, there was always a focus on the perspective of the nurse. One way to foster empathy and reflective practice is to have people experience another's reality. In the past, this was accomplished through personal experiences with the healthcare system and/or trying to view a situation from the perspective of the patient. The adoption of virtual reality allows nurses to experience the patient perspective of health, illness, and the healthcare system. Throughout the immersive

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1. CARING values: Collaboration & cultural humility, Advocacy, Rurality, Innovation & openness, Nurture - self & those we care for, Growth & life-long learning

experience, students navigate the complex emotions of being a patient. Nursing faculty then provide a guided debriefing experience so that students can discuss the various experiences with their classmates. After the virtual reality simulation, students also write about the experience to further the reflection process with such questions as: how did you feel, was it different from what you expected, and how will you grow from these experiences? Often, these types of questions or reflective practices can be incongruous with the apparatus of the education and healthcare systems, which focus on evaluation, assigning, testing, and the separation of providers from the patient experience. Students must be fully engaged with the education, for a transformative educational experience where students broaden their knowledge, skills, and attitudes/dispositions.

The content within the coursework provides students with the multifaceted experience so they can foster a culture of healing, community, and connection within their workplace and professions through reflective practice. Although the nursing program facilitates reflective practice through activities and assignments, students need to continue these activities outside of class for reflective practice to become part of their routine. Through reflection, HCPs are able to find a safe space to honor and release emotions that arise while caring for people who experience the miracles and tragedies of life.

Going forward, we want to cultivate cross disciplinary partnerships with narrative medicine experts in Psychology and English to compile and better understand stories from nurses. We hope that this study of our own students and our teaching might open the door to collaboration and storytelling among other disciplines. Ultimately, we want to shift the culture of care across applied health fields to embrace vulnerability and caring as a strength in delivering patient care.

References

American Association of Colleges of Nursing. 2019. "Nursing Fact Sheet." Washington, DC: American Association of Colleges of Nursing. Retrieved Sept. 2, 2022. https://www.aacnnursing.org/News-Information/Fact-Sheets.

American Nurses Association. 2015. *Code of Ethics for Nurses*. Silver Springs, MD: American Nurses Publishing.

Awan, Sana, Mufaddal N. Diwan, Alifiya Aamir, Zoha Allahuddin, Muhammad Irfan, Alessandro Carano, Federcia Vellante, Antonio Ventriglio, Michele Fornaro, Allesandro Valchera, Mauro Pettorruso, Giovanni Martinotti, Massimo Di Giannantonio, Irfan Ullah, and Domenico De Berardis. 2022. "Suicide in Healthcare Workers: Determinants, Challenges, and the Impact of COVID-19." *Frontiers in Psychiatry 12*. https://doi.org/10.3389%2Ffpsyt.2021.792925.

Betensky, Mala G. 1995. *What Do You See? Phenomenology of Therapeutic Art Expression*. London, England: Jessica Kingsley Publishers.

Boud, David, Rosemary Keogh, and David Walker. 2013. *Reflection: Turning Experience into Learning*. London and New York: Routledge Falmer.

Broadbent, Elizabeth, Jan W. Schoones, Jitske Tiemensma, and Ad A. Kaptein. 2018. "A Systematic Review of Patients' Drawing of Illness: Implications for Research Using the Common Sense Model." *Health Psychology Review* 13(4):1–21. https://doi.org/10.1080/17437199.2018.1558088.

California Legislative Senate Bill 628. California Creative Workforce Act of 2021. Chaptered date: 10/09/21. https://leginfo.legislature.ca.gov/faces/billStatusClient.xhtml?bill_id=202120220SB628.

Center for Mind-Body Medicine. 2023. "About CMBM." Washington, D.C.: The Center for Mind-Body Medicine. Retrieved January 10, 2023. https://cmbm.org/.

Charon, Rita. 2008. *Narrative Medicine: Honoring the Stories of Illness*. New York: Oxford University Press.

Charon, Rita. 2009. "Narrative Medicine as Witness for the Self-Telling Body." J*ournal of Applied Communication Research* 37(2):118-131. http://dx.doi.org/10.1080/00909880902792248.

Charon, Rita. 2017. "Introduction." T*he Principles and Practices of Narrative Medicine*. Eds. Rita Charon, et al. New York: Oxford University Press.

Clance, Pauline R. and Suzanne A. Imes. 1978. "The Imposter Phenomenon in High Achieving Women: Dynamics and Therapeutic Intervention." *Psychotherapy: Theory, Research & Practice* 15(3):241–47.

Daryazadeh, Saeideh, Payman Adibi, Nikoo Yamani, and Roya Mollabashi. 2020. "Impact of a Narrative Medicine Program on Reflective Capacity and Empathy of Medical Students in Iran." *Journal of Educational Evaluation for Health Professions* 17(3):1-7. https://doi.org/10.3352/jeehp.2020.17.3.

DasGupta, Sayantani. 2008. "The Art of Medicine: Narrative Humility." *The Lancet* (British edition) 371(9617):980–981. https://doi.org/10.1016/S0140-6736(08)60440-7.

DasGupta, Sayantani. Personal Website. 2022. http://www.sayantanidasgupta.com/doctor/about.

DasGupta, Sayantani and Marsha Hurst. 2007. S*tories of Illness and Healing: Women Write Their Bodies*. Kent, Ohio: Kent State University Press.

DasGupta, Sayantani and Rita Charon. 2004. "Personal Illness Narratives: Using Reflective Writing to Teach Empathy." *Academic Medicine: Journal of the Association of American Medical Colleges* 79(4):351–56.

Davidson, Judy E., James Proudfood, Kelly Lee, Garni Terterian, and Sidney Zisook. 2020. "A Longitudinal Analysis of Nurse Suicide in the United States (2005-2016) with Recommendations for Action." *Worldviews on Evidence-Based Nursing* 17:6-15. https://doi.org/10.1111/wvn.12419.

Davies, Nicola. 2021. "Understanding Grief in Nursing." *Independent Nurse for Primary Care and Community Nurses*, May 13. Retrieved July 6, 2022. https://www.independentnurse.co.uk/professional-article/understanding-grief-in-nursing/237189/.

ElKayal, Manal Mohamed and Safaa Mohamed Metwaly. 2022. "Effectiveness of Mindfulness-Based Intervention on Post-Traumatic Stress Symptoms Among Emergency Nursing Students." *Middle East Current Psychiatry* (Cairo) 29(1):1–13.

Fancourt, Daisy and Saoirse Finn. 2019. "What Is the Evidence on the Role of the Arts in Improving Health and Well-being? A Scoping Review." *Health Evidence Network Synthesis Report* 67. World Health Organization.

Fogarty, Colleen T. 2009. "55-Word Stories: Introducing the 55-Word Stories Feature Section." *Families, Systems, & Health* 27(3):284-285.

Gautam, Anamika, Srinivasan Palanivelu, and Gurvinder Kaur. 2020. "Effectiveness of Mindfulness Based Stress Reduction Program (MBSR) on Stress Among Nursing Students- a Mixed Method Study." *International Journal of Community Medicine and Public Health* 7(9):3547–3552. http://dx.doi.org/10.18203/2394-6040.ijcmph20203921.

Gilligan, Heather T. 2021. "Nurses at High Risk for Suicide: 'I just wanted all of it to stop'," *California Health Care Foundation*, May 24. https://www.chcf.org/blog/nurses-high-risk-suicide-just-wanted-all-stop/.

Gordon, James S. 2019. *The Transformation: Discovering Wholeness and Healing After Trauma*. San Francisco: HarperOne.

Greeson, Jeffrey M., Michael J. Toohey, and Michelle J. Pearce. 2015. "An adapted, Four-Week Mind-Body Skills Group for Medical Students: Reducing Stress, Increasing Mindfulness, and Enhancing Self-Care." *Explore* (NY) 11(3):186-192. https://doi.org/10.1016/j.explore.2015.02.003.

Gregg, Melanie. 2020. "The Breakthrough I've Been Waiting For: College Writing and Graphic Memoirs of Illness and Caregiving." *Graphic Medicine* 2022. https://vimeo.com/725873876/da6a636aa0.

Guillemin, Marilys and Lynn Gillam. 2015. "Emotions, Narratives, and Ethical Mindfulness." *Journal of the Association of American Medical Colleges* 90(6):726–31.

Haddad, Lisa M., Pavan Annamaraju, and Tammy J. Toney-Butler. "Nursing Shortage. [Updated 2022 Feb 22]." *StatPearls [Internet]*. Treasure Island, Florida: StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK493175/.

Hass-Cohen, Noah, Joanna C. Findlay, Richard Carr, and Jessica Vanderlan. 2014. "'Check, Change What You Need To Change and/or Keep What You Want': An Art Therapy Neurobiological-Based Trauma Protocol." *Art Therapy*

31(2):69–78. http://dx.doi.org/10.1080/07421 656.2014.903825.

Hills, Marcia and Jean Watson. 2011. *Creating a Caring Science Curriculum: An Emancipator Pedagogy for Nursing*. New York: Springer Publishing Company.

Horton-Deutsch, Sara and Gwen D. Sherwood. 2017. *Reflective Practice: Transforming Education and Improving Outcomes*. Indianapolis, IN: Sigma Theta Tau International.

John, Stephanie. 2019. "Imposter Syndrome: Why Some of Us Doubt Our Competence," *Nursing Times*, January 28. https://www.nursingtimes.net/ roles/nurse-educators/imposter-syndrome-why-some-of-us-doubt-our-competence-28-01-2019/.

Kagan, Paula N. 2006. "Jo Ann Ashley 30 Years Later: Legacy for Practice." *Nursing Science Quarterly* 19(4):317–327. https://doi. org/10.1177/0894318406293121.

Kaimal, Girija, Kendra Ray,and Juan Muniz. 2016. "Reduction of Cortisol Levels and Participants' Responses Following Art Making." *Art Therapy* 33(2):74–80. https://doi.org/10.1080% 2F07421656.2016.1166832.

Kelsey, Catherine and Hayes, Sally. 2015. "Frameworks and Models – Scaffolding or Strait Jackets? Problematising Reflective Practice." *Nurse Education in Practice* 15(6):393–396. https://doi.org/10.1016/j. nepr.2015.05.006 Permalink.

Kinman, Gail, Sandra Leggetter, Peter A. Leggat, and Derek R. Smith. 2016. "Emotional Labour and Wellbeing: What Protects Nurses?" *Healthcare* 4(4):1-12.

Knaak, Stephanie, Ed Mantler, and Andrew Szeto. 2017. "Mental Illness-Related Stigma in Healthcare." *Healthcare Management Forum* 30(2):111-116. https://doi.org/10.1177%2F0840470416679413.

LaPenna, Denise and Joseph D. Tariman. 2020. "Art Therapy: A Literature Review of Efficacy in Improving Psychosomatic Symptoms in Patients with Cancer." *Clinical Journal of Oncology Nursing* 24(2):123–26.

Lutz, Gabriele, Christian Scheffer, Friedrich Edelhaeuser, Diethard Tauschel, and Melanie Neumann. 2013. A Reflective Practice Intervention for

Professional Development, Reduced Stress and Improved Patient Care—A Qualitative Developmental Evaluation. *Patient Education and Counseling* 92(3):337–345. https://doi.org/10.1016/j. pec.2013.03.020.

MacLaughlin, Brian W., Dan Wang, Anne-Michelle Noone, Nan Liu, Nancy Harazduk, Michael Lumpkin, Aviad Haramati, Pamela Saunders, MaryAnn Dutton, and Hakima Amri. 2011. "Stress Biomarkers in Medical Students Participating in a Mind Body Medicine Skills Program." *Evidence-based Complementary and Alternative Medicine* 2011(950461). https://doi. org/10.1093%2Fecam%2Fneq039.

Mehl-Madrona, Lewis. 2007. "The Nature of Narrative Medicine." *The Permanente Journal* 11(3):83-86. doi:10.7812/TPP/07-052

Mema, Briseida, Andrew Helmers, Cory Anderson, Kyung-Seo Min, and Laura E Navne. 2021. "Who am I? Narratives as a Window to Transformative Moments in Critical Care." P*loS One* 16(11):e0259976–e0259976. https://doi. org/10.1371/journal.pone.0259976 .

Monroe, Todd and Heidi Kenaga. 2011. "Don't Ask Don't Tell: Substance Abuse and Addiction among Nurses." *Journal of Clinical Nursing* 20(01).

Nolan, Gregory, Lucy Dockrell, and Suzanne Crowe. 2020. "Burnout in the Paediatric Intensive Care Unit." *Current Pediatrics Reports* 8(4):184–88.

Park, Kwi Hwa, Bee Sung Kam, So Jung Yune, Sang Yeoup Lee, and Sun Ju Im. 2022. "Changes in Self-Reflective Thinking Level in Writing and Educational Needs of Medical Students: A Longitudinal Study." *PloS One* 17(1):1-11. https://doi. org/10.1371/journal.pone.0262250.

Peng, Ying, Shao-Wen Xiao, Hui Tu, Xiao-Yun Xiong, Zhao-Jia Ma, Wen-Jun Xu, and Ting Cheng. 2022. "The Impostor Phenomenon among Nursing Students and Nurses: A Scoping Review." *Frontiers in Psychology* 13(809031): 1-8. https:// doi.org/10.3389/fpsyg.2022.809031.

Saad, Lydia. 2022. "Military Brass, Judges Among Professions at New Image Lows." *Gallup*, January 12.

https://news.gallup.com/poll/388649/military-brass-judges-among-professions-new-image-lows.aspx .

Schmidt, Madeline and Kirstin Haglund. 2017. "Debrief in Emergency Departments to Improve Compassion Fatigue and Promote Resiliency." *Journal of Trauma Nursing* 24(5):317–322. https://doi.org/10.1097/JTN.0000000000000315.

Sierpina, Victor S., Mary Jo Kreitzer, Elizabeth Mackenzie, and Michelle Sierpina. 2007. "Regaining Our Humanity Through Story." *EXPLORE: The Journal of Science & Healing* 3(6):626–632. https://doi.org/10.1016/j.explore.2007.09.012.

Tervalon, Melanie and Jann Murray-García. 1998. "Cultural Humility Versus Cultural Competence: A Critical Distinction in Defining Physician Training Outcomes in Multicultural Education." J*ournal of Health Care for the Poor and Underserved* 9(2):117–125.

U.S. Department of Health and Human Services, Office of the Surgeon General. 2022 "Addressing Health Worker Burnout; the US Surgeon General's Advisory on Building a Thriving Workforce" https://www.hhs.gov/surgeongeneral/priorities/health-worker-burnout/index.html.

van der Riet, Pamela, Tracy Levett-Jones, and Catherine Aquino-Russell. 2018. "The Effectiveness of Mindfulness Meditation for Nurses and Nursing Students: An Integrated Literature Review." *Nurse Education Today* 65:201–211. https://doi.org/10.1016/j.nedt.2018.03.018.

Weinlander, Eva E., Eric J. Gaza, and Marcy Winget. 2020. "Impact of Mind-Body Medicine Professional Skills Training on Healthcare Professional Burnout." *Global Advances in Health and Medicine* 9. https://doi.org/10.1177/2164956120906396.

Wexler, Teressa M., and Jana Schellinger. 2022. "Mindfulness-Based Stress Reduction for Nurses: An Integrative Review." *Journal of Holistic Nursing*. https://pubmed.ncbi.nlm.nih.gov/35213264/.

Yagelski, Robert. 2009. "A Thousand Writers Writing: Seeking Change through the Radical Practice of Writing as a Way of being." *English Education* 42(1): 6-28.

Yahyaei, Asma A, Alistair Hewison, Nikolaos Efstathiou, and Debbie Carrick-Sen. 2022. "Nurses' Intention to Stay in the Work Environment in Acute Healthcare: A Systematic Review." *Journal of Research in Nursing* 27(4):374-397. https://doi.org/10.1177/17449871221080731.

Zaharias, George. 2018. "What Is Narrative-Based Medicine?" *Canadian Family Physician* 64(3):176–180.

Zytkoskee, Adrian M. 2020. "Reflective Writing in Medical Education: A Writing Professional's Exploration of Purposes and Practices." Dissertation.