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FEATURED ARTICLES

“It Captures the Rawness and Reality”: Exploring Student Emotion During an Illness Narrative Assignment in Doctor of Physical Therapy Curricula

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Abstract

Purpose: **The purpose of this qualitative study was to explore first year doctor of physical therapy student emotions when completing a first-person illness narrative assignment within a required Whole Person Care course early in curricula.**

Method: **First-year physical therapy students from one physical therapy program completed an illness narrative assignment of a known individual with an illness experience using a first-person perspective. Qualitative data from students' reflections from the open-ended prompt “How did you feel when writing the illness narrative?” were analyzed and coded retrospectively.**

Results: **Diverse emotions organically emerged from the qualitative data. Coded emotions correlated with 13 of Cowen and Keltner's 27 emotion categories further demonstrating the wide variety of emotions experienced by students. Student reflection on the illness narrative assignment provided opportunity for emotional engagement pertaining to the human illness experience.**

Discussion: **The use of illness narrative may meet the needs of novice learners by providing space to connect emotion to the provision of healthcare early in curricula prior to clinical experience. Students used authentic context to fit new information to previous experience and emotion to create meaning and learning about provision of whole person care. The exploration of emotion within the assignment revealed a wide range of emotion potentially impacting professional identity formation, compassion, motivation, and greater understanding of the human illness experience. This study may serve as launching point for harnessing the power of narrative and emotion to support physical therapy student learning in the provision of whole person care. The results have implications for educational interventions using narrative and leveraging the emotional aspects of learning to advance student professional identity formation and compassionate care early in curricula and contribute to the limited research in emotion and narrative pedagogy in physical therapy education.**

Keywords: Physical therapy education, Emotion in learning, Narrative pedagogy, Illness narrative, Professional identity formation

1. Introduction

The statement “we feel, therefore we learn” reflects the current evidence regarding the inseparable connection between emotion and learning illuminated in neuroscience research [1]. Emotion is additionally embedded in the provision of healthcare because at the core of healthcare is the human experience. Previously, healthcare education has emphasized cognitive components of learning while often omitting feelings and emotion [2]. In healthcare provision there can be a battle between hiding emotion and demonstrating emotion representing the care and compassion vital to person centered care [3]. As opposed to separation of emotion from healthcare provision, Heyhoe et al. [4] suggest that emotion in healthcare is linked to

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patient safety and clinical decision making. The authors call for recognizing the powerful impact of emotion in patient care positing cultivation of a culture that values both emotion and reflective practice [4]. In agreement, Schwartz et al. describe the inextricable nature of emotion of both the clinician and the patient, impacting the interpersonal relationship established for effective healthcare [5]. They champion the importance of student emotion recognition and regulation in healthcare education in the book *Emotion in the Clinical Encounter* [5].

Increasingly, researchers in neurobiology assert that emotion cannot be separated from cognition and learning [6]. Advances in neuroscience research reveals that emotions impact memory, attention, interest, motivation, and reasoning [1,2,7]. Research by Gillam et al. [8] revealed healthcare educators agreed on the importance of the role of emotion in healthcare education. The authors proposed acknowledging and reflecting on emotions during education as an important component of clinical practice facilitating learning ethical values and reasoning [8]. In addition to ethics, literature confirms that emotions, from clinician and those perceived from patient, affect clinical decision making [9]. Authors suggest creating opportunities for strengthening the emotional competence in future clinicians and that education should highlight the importance of emotional proficiency to support clinical decision making [9].

Beyond ethics and clinical decision making, emotion impacts student professional identity development [10]. Emotions have been found to be strongly related professional identity development and researchers suggest explicitly addressing emotions during curricula [3]. In agreement, McNaugton asserts emotion be considered as “an integral part of professional development.” [11] A literature review on emotion and feedback in healthcare education found that transformative learning can occur when emotions are acknowledged and reflected on in a supportive educational environment [10]. Schwartz et al. [5] argue that emotion is an essential component of healthcare delivery and assert an integral part of healthcare education should be student recognition and response to emotion.

A pedagogical tool used in healthcare education to promote emotional awareness, empathy, patient-centered care, and professional development is narrative. Greenfield et al. posits narrative as a way of sensemaking for students and using patient and family perspectives to support clinical care in physical therapy [12]. In agreement, Edwards suggests narrative can be used for professional development revealing what it means to be human, advancing reflection, and used to deepen the emotional awareness of clinical practice [13]. Physical therapy students demonstrated increased patient-centered focus, increased empathy, emphasis on quality of care, and individualized care after completion of a narrative reasoning course [14]. The course was also found to impact student professional identity as they generated new perspectives on their role as a healthcare provider and role of the patient [14]. Another study examining the impact of personal illness narratives on medical, nursing, and medical family therapy students found that professional identity development and meaning of illness were influenced [15]. Opportunities for reflection on previous personal illness experiences supported a relational perspective to illness and impacted student perception of their professional role [15]. Concurring with previous research, narrative reasoning during clinical education was found to shift focus of identity from student to clinician, increase emphasis on patient-centered care, and develop reflective skills, therapeutic alliance, and empathy [16].

The evidence highlights that emotion and narrative both have a germane role in learning and the provision of whole person healthcare. Students noted impactful learning and deeper understanding of the human illness experience from completing the illness narrative assignment in a previously published study [17]. The primary purpose of this paper is to explore the emotions experienced by doctor of physical therapy students during an illness narrative assignment in a whole person care course prior to clinical education. An additional purpose is to highlight how narrative may be used to explore emotion in the human illness experience to support person-centered care.

2. Method

For thorough reporting of this qualitative research, The Consolidated Criteria for Reporting Qualitative Research (COREQ) reporting guide was used and components addressed [18].

2.1. Research team and reflexivity

The authors include two faculty, one Caucasian male with a Doctorate of Ministry and one Caucasian female with a Doctorate in Physical Therapy. Each has some experience completing qualitative research and are faculty at the same private parochial university with the foundational value of whole-person care. They both teach physical therapy

students influencing subject inclusion and interest. The authors are employed by different schools within the university and are married. The second author has been teaching Whole Person Care in the School of Nursing, School of Dentistry, School of Medicine, and School of Allied Health. At the initiation of this retrospective study, he was no longer instructor to the students. The first author is faculty in the physical therapy program and has interest in narrative medicine and student professional identity formation. The research methods were impacted by use of retrospective data from a completed course limiting data triangulation. The authors acknowledge their positionality and personal value placed on narrative and emotion in healthcare education to support patient-centered care impacted interest in this field, potentially influencing interpretation of the qualitative data and results.

2.2. Study design and theoretical framework

The study design was exploratory, using qualitative data from student reflections about completing an illness narrative assignment early in didactic curricula. Because data constituted de-identified reflections from a course retrospectively taught, the university institutional review board determined this study did not meet the definitions of human subject research. The study's theoretical framework was constructivist, based on the assumption that individual experience impacts meaning and interpretation of experienced events [19]. A phenomenological approach was integrated to understand student “lived experience” as student-perceived emotions while completing the illness narrative assignment were explored [19].

2.3. Participants and setting

Participant selection was purposive for this study with data from one cohort of first-year physical therapy students in one physical therapy program. The average age of the participants was 24.3 years and included 25 males and 34 females. The 59 students identified with the following ethnicities; American/Indian or Asian/Indian 5, Asian 14, Black/ Hispanic 1, Caucasian 16, Hispanic 20, and 2 students did not identify with a particular ethnicity. The setting included first year doctor of physical therapy students, in the second quarter of didactic education, prior to clinical education, who had completed a required Whole Person Care course. The 10-week course was attended weekly by students during 2 hour face-to-face sessions and taught by the second author, a faculty member within the university's school of religion. The purpose of the course, designed via interprofessional collaboration, was to introduce the concept of the biopsychosocialspiritual framework of patient care to champion whole person care [20]. The course additionally aimed to support the development of compassionate and empathic health care providers. Multiple pedagogical strategies were incorporated including discussion, role-playing, written reflection, and student presentations.

2.4. Procedure

Students were assigned the illness narrative assignment the first week of the course and it was due the third week. The assignment was to write a first-person narrative of a family member or friend with an illness experience. Assuming the perspective of a known individual allowed students to encounter what the individual might have experienced during illness. Including the illness narrative in the course was designed to facilitate awareness of emotion regarding illness, facilitate perspective-taking, and compassion. Multiple prompts were included in the assignment, such as: In what ways did your role change as a result of this illness? What thoughts and feelings did you experience in relation to this illness? What happened to your body as a result of the illness? What faith, religion, or personal philosophy helped you cope (or hindered your coping) with this illness? Does the future look any different to you as a result of having this illness? See Appendix A for assignment prompts in entirety. Students could choose from a variety of literary forms: story, journal, or poem. The assignment was required to be single spaced, typed, and at minimum 1-page in length. Students chose illnesses such as lung cancer, stroke, Alzheimer's disease, eating disorders, diabetes, Covid-19, pancreatic cancer, rheumatoid arthritis, depression, motor vehicle accidents, dementia, heart attack, and breast cancer. Not all students named the illness that their narrative was based on in the reflection questions, some described acute on chronic conditions, 25 detailed long-term, chronic conditions, and 8 were distinctly acute illness experiences. Assignment completion for the pass/fail course was required, and feedback/response from instructor given, as opposed to a grade. After writing the narrative, students were asked to reflect on the experience and process of writing the illness narrative. There were multiple prompts for student reflection (See Appendix A). The single open-ended reflection prompt “What did you feel when writing the illness narrative?” was analyzed as the data source for this

study, however was not pilot-tested. Students completed the assignment independently at their convenience and submitted both the illness narrative and responses to the reflection questions electronically into the learning management system. Two reflections on the illness narrative were not used in data analysis as the student's own illness experience was described rather than an illness experience of a friend or family member. These reflections were not included as assignment intent was exploring the perspective of another. The de-identified reflections were retrospectively gathered after completion of the Whole Person Care course as a data source.

2.5. Analysis

Data analysis involved an inductive, emergent approach. A graduate assistant not associated with the study de-identified student reflections in preparation for qualitative data analysis. Any other potentially identifying data was also removed to protect student anonymity. Verbatim data was imported into Dedoose, version 8.0.35 (2018), a web-based application for storing, coding, and analyzing qualitative data. Two authors read the qualitative data and meaningful phrases in student reflections answering the question "What did you feel when writing the illness narrative?" were coded separately for increased trustworthiness of data analysis. Codes emerged organically and were not pre-established. Iteratively, parent and child codes were created, merged, and adjusted as data was analyzed to establish themes. Code agreement and cross-checking was required to improve trustworthiness. Regular discussions on emerging themes transpired to ensure consensus. Because de-identified reflections were analyzed from a previously taught course, multiple data sources for triangulation was not feasible.

Twenty-six initial emotion codes were identified. These codes were juxtaposed to the 27 dimensions of emotions determined by Cowen and Keltner (2017) [21]. Their research discovered 27 self-reported emotional experiences, arguing that emotion categories beyond the discrete emotion theories [22] are necessary to precisely disclose the self-reported emotional experiences [21]. In the present study, the initial 26 emotion codes aligned to 13 of the 27 emotional experiences described by Cowen and Keltner (2017) [21]. Nine respondents described feeling emotional but did not further delineate what type of emotions were perceived. These responses were not coded secondary to lack of specificity.

3. Results

Qualitative responses from the open-ended reflection question "What did you feel when writing the illness narrative?" revealed notably diverse emotional experiences. Some students felt uncertain and inadequate while completing the assignment. Other students revealed they felt positive and had a sense of enlightenment or closure. In other extremes, students reported feeling peace and gratitude, while some expressed feeling scared or frustrated. The coded self-reported emotions aligning to 13 of Cowen and Keltner's (2017) emotion categories with frequencies are noted in Table 1 with supporting excerpts.

The category of "entrancement" was most frequently aligned which Cowen and Keltner define as "interest, amazement, feeling intriqued." [21] Reflecting the amazement one student stated "I put myself into the person's position more actively and it's almost as if it was me. Crazy feeling." Another student stated "I was surprised by the thoughts that came to my mind. The feeling of putting your feet in another person's shoe makes a big difference, because the perspective and feelings change." On the other hand, some students experienced uncertainty in attempting to express another's illness journey stating "It was her life and experience, who am I to speak on her behalf? What if I am way off base on what she went through?" Despite discomfort, another student found a sense of meaning in their role stating "I've learned how touching it is to revisit the experience, it's painful but it serves as a remembrance for why I'm here." Acknowledging the impact of the assignment and emotional engagement incurred, another student reported "I feel like it captures the rawness and reality" of an illness journey.

4. Discussion

The use of narrative for learning is anchored in learning theory. Learning theories, such as the constructivism learning theory and situated learning theory advocate for using learner's previous experiences and reflecting on those experiences to facilitate understanding [23,24]. Additionally, the situated learning theory advances learning as a social process and when applied in authentic contexts contributes to greater meaning [24]. During completion of this assignment students used authentic context to fit new information to previous experience or knowledge to create meaning to facilitate learning about provision of whole person care.

Clinical care is replete with emotion, both for health care providers and patients. Learners with

Table 1. Coded emotions correlated with 13 of Cowen and Keltner's emotion categories with supporting excerpts.

13 final coded emotion categories (Cowen and Keltner, 2017)	Initial coded student emotions (frequency in parentheses)	Qualitative Example
Adoration	Gratitude (13)	"I'm grateful to have had the space to talk about this more, and I look forward to sharing this part of my life with others." "I am glad I wrote about this because it almost felt like an unloading of everything I had tried to keep inside"
Admiration	Pride (4)	"It made me also feel proud of her that she was able to overcome the way she has so far."
Anxiety	Uncertainty (7), nervous (1), guilt (1), inability to understand (3), questioning (1)	"I was honestly quite hesitant to write about my mom for this narrative, worried about the feelings it may bring up again."
Calmness	Peace (2)	"I felt at peace because of the amount of adversity she had to overcome and the amount of improvement she had completed, which needed to be shared."
Confusion	Frustration/difficult (16), hopeless (1), inadequacy (6)	"I still cannot imagine what it must have felt like at that moment." "I found it hard trying to find areas of her journey where I could put myself in her shoes especially after only getting glimpses of her journey."
Empathic Pain	Empathy (4)	"Gave me a sense of empathy for how she was feeling regardless of how she was portraying herself."
Entrancement	Greater understanding (8), inspired/impactful/meaning-making (3), enlightening (13), eye-opening (6), novel/new thoughts (3)	"In some ways I feel that I understand her situation a little better now after writing this." "I realized how beautiful her life was" "I've never really thought about how his experience must have been like, especially for being so young."
Fear	Scared/Vulnerable (4)	"putting myself in my sister's shoes felt terrifying to re-live and see what she was going through" "The process of writing this narrative was scary to me"
Interest	Interesting/Intrigue (4)	"It was intriguing to reflect on a season from almost 6 years ago"
Joy	Enjoyment (2)	"I felt that I really enjoyed writing out my experience in this illness narrative."
Nostalgia	Nostalgic/reflective (11)	"this did force me to fully reflect on the last months of her life" "The writing process was nostalgic to say the least." "it put things into perspective"
Relief	Closure (3) Forgiveness (1) Relief (3)	"In writing this I felt that I deeply relieved the pain as well as the healing that came with the experience." "I did feel a slight sense of closure in myself. We sometimes shut ourselves off from emotions that are difficult to confront"
Sadness	Sad (15), Regret (1)	"It made me feel selfish and sad for not trying to understand my sister better." "writing this piece gave me an internal sense of deep sadness"

limited clinical experience may have difficulty relating to emotion both in themselves and from the patient in the clinical encounter. This assignment, early in curricula, prior to clinical education, induced a rich variety of emotions by students. Emotions were likely impacted by the student choice of narrative and whose first person voice they represented in the narrative assignment. For students, it was possibly easier to complete the assignment about someone's experience they knew well, however, this may have made completion of the assignment more difficult emotionally. Exploring emotion through illness narrative early in curricula may proxy for the vital clinical education experiences students don't typically encounter until later in the program. This potentially expediates student learning navigating emotion and value of person-centered care earlier in curricula.

Early studies on emotion categorize emotion into six basic emotional states [22]. In contrast, a 2017 study examining emotion identified 27 self-reported varieties of emotional experiences reported by participants including: admiration, adoration, aesthetic appreciation, amusement, anger, anxiety, awe, awkwardness, boredom, calmness, confusion, craving, disgust, empathic pain, entrancement, excitement, fear, horror, interest, joy, nostalgia, relief, romance, sadness, satisfaction, sexual desire, and surprise. In opposition to the discrete theories of emotion, results revealed that more classifications of emotion were required to capture the variety of reported emotional experiences of participants, also revealing gradients of emotion, rather than few discreet emotions [21]. The final coding of student emotions to the 27 more nuanced categories of emotion determined by Cowen & Keltner [21] was chosen for two reasons. First, their study was based on participant self-report, identical to the present study. Additionally, it was chosen to preserve the wider spectrum of student emotions revealed when completing the narrative contributing to richer nuanced understanding of the student experience when completing the assignment. The authors felt coding to basic emotion models, which limit emotion categories to five or six, would dilute the rich emotional experiences expressed by students. Coded student descriptions of emotion were congruous with 13 different dimensions, almost half of all the categories of emotion established by Cowen and Keltner [21]. This reflects the unique variety of emotion experienced by students during one assignment in a Whole Person Care course. Addressing student and future patient emotions is challenging however results from the present study can provide educators with curricular design ideas to harness student emotion for rich educational opportunities.

In the present study, nine students reported feeling “emotional” rather than defining the specific emotions felt which prevented coding to one of the 27 dimensions. This could be because some students lacked the emotional vocabulary to describe their emotional experiences. In contrast, labeling emotion with greater specificity has been shown to reinforce greater emotional regulation [25] and generate more positive emotions [26]. Training students in affect labeling and emotional intelligence may provide healthcare educators an opportunity to support future healthcare providers’ emotional regulation and well-being.

Beyond well-being, student recognition and response to emotion in learning has been linked to an awareness of professional role and professional identity formation. Recent emphasis in healthcare education has been professional identity formation as a primary educational goal with the focus on “being” or “becoming” a healthcare professional rather than “doing.” The pedagogical strategy of including a narrative assignment early in curricula to facilitate awareness of emotion regarding the illness journey may contribute to facilitation of meaning, role, identity, and morality, advancing earlier development of student professional identity.

Research reveals that emotion and learning cannot be separated. Emotional engagement during learning creates personal relevance which can motivate students. As noted by Immordino-Yang (2016), failing to acknowledge the significance of student emotion within the space of learning may mean neglecting the most important student motivation for learning [7]. Appreciating emotion with intentionally designed learning activities may encourage learning motivation which reciprocally supports deeper learning, thinking, and clinical decision making. Rather than avoiding emotion or separating emotion from learning, the results from this study can provide educators with ideas on how to use emotion to make learning meaningful and to support cognition and thinking about professional role.

Students had a wide variety of emotions during completion of the illness narrative. Some emotions, such as fear and sadness, could be potentially detrimental to learning. Effort by educators to ensure psychological safety of students to navigate difficult student emotional responses may needed. A debriefing session after illness narrative completion to provide safe place to examine and cope with difficult emotions may be beneficial. Faculty may

require additional professional development to understand how to adequately support students with varying emotional responses in order to channel emotions effectively, encourage emotional regulation, and to support future patient care.

The exploration of emotion within the assignment revealed wide ranges of emotion potentially impacting professional identity formation, motivation, compassion, and greater understanding of the human experience through an illness journey. As one student expressed, the illness narrative was "definitely a golden tool I can practice even if it's just in my head. It helps me get in touch with my feelings and allows me to see another person's life more vividly."

5. Limitations and delimitations

A delimitation of this research was the exploration of emotions during the completion of one illness narrative assignment. This was intentional to explore immediacy of emotions experienced and to limit the scope of the research. Limitations include subjects within one first-year cohort in one physical therapy program. Students were asked to write an illness narrative from the perspective of a friend or family member for the assignment. Inability to determine how well students knew the individual they wrote about is a limitation to this research. An additional limitation was use of written reflections, rather than interviews, limiting the ability for follow-up questions and clarification. Further research is needed to explore student regulation of emotion as well as student-perceived impact on learning and future patient care.

6. Conclusion

Research demonstrates the inability to separate emotion from learning and highlights the important role of clinician emotion for motivation, meaning, sensemaking, patient safety, and clinical decision making. Accentuating the role of emotion in healthcare education curricula can support learning, motivation, professional identity formation, and provision of person-centered care. This study contributes to the limited research and understanding of narrative pedagogy and emotions associated with learning during physical therapy curricula. It also serves as a launching point for exploring the navigation of emotion in physical therapy education. The authors hope that the results motivate educators to harness the power of narrative and emotion to support physical therapy student learning in the provision of person-centered care.

Ethical approval

The Loma Linda University institutional review board determined this study did not meet the definitions of human subject research January, 2022.

Other disclosures

None.

Appendix A.

Choose an illness experience of a family member or friend. No matter which of these you choose, write about it as if it were personal or as if it had happened to you. In other words, write the narrative from first-person perspective as if you were that person. You can choose from a variety of forms: story, journal, or poem. Use one of these forms and write it from a first-person perspective. It must be typed, single spaced and 1-page in length (or longer).

Below are some questions to guide your writing. They are only guidelines. You will not be able to cover all of them. Choose the ones that are most interesting to you and concentrate on writing "your" illness story. (Do not simply generate a list of answers to the questions.) Your narrative must include a responses to number 12.

1. **Background story of the illness**

a. What precipitated the illness?

b. Did someone else in your family or circle of friends also have the illness?

c. What were your attitudes towards people who had this illness before this (or any illness)?

2. **Becoming aware of the illness**

a. How did you find out about the illness (gradual, someone informed you, a test, etc.)

b. What was it like it to access care or get an explanation?

c. What thoughts or feelings did you have as you became aware of the illness?

d. Did the world seem different when you became aware of the illness? Did your perceptions change, strengthen or lessen?

3. **The body**

a. What happened to your body as a result of the illness?

b. How did it change or remain the same?

c. What did others do to your body or how did they respond to it?

d. How did you treat your body in relation to the illness?

4. **Roles – In what ways did your role (as a son, daughter, mother, father, friend, and student) change as a result of this illness?**
5. **Comparisons – If you were to compare this illness to something else (i.e. "having this illness is like …") what would you compare it to and why?**
6. **Thoughts and feelings**

a. What thoughts and feelings did you experience in relation to this illness?
b. How did you deal with those thoughts and feelings? Are there people you shared them with? Did you journal, seek counseling?|c. How have the media and others portrayed this illness and what do you think and feel about how it is portrayed?

7. **Relationships**

a. How did your loved ones deal with your illness? Did they act the same/different?
b. Were some relationships strengthened or threatened by the illness? If so, in what ways?
c. What were the interactions like with medical staff?

8. **Pain and medical care**

a. What was the role of pain in this illness?
b. In what ways were others aware or not aware of your pain?
c. Did you receive the help you needed from medical staff? Is there a particular person from the medical staff who was especially helpful or not helpful? In what ways?

9 Culture/ethnicity - What role (if any) did culture and ethnicity play in your illness (meaning of illness, resources, impact, etc.)

10. **Faith/spirituality/religion**

a. What faith, religion, or personal philosophy helped you cope (or hindered your coping) with this illness?
b. Did you have a religious community that knew about your illness? If you had a community of faith but did not let the community know about it, what was the reason?
c. What happened to your own spirituality or faith as a result of the illness?
d. What role did you see God playing in relation to your illness?

11. **The future**

a. Does the future look any different to you as a result of having this illness?
b. What role do you expect the illness to have in your life after today?
c. How will this experience affect the way you treat others, view life, or live your own life?

12. **REQUIRED: Reflection on the personal illness narrative experience, as a whole:**

a. Why did you choose your personal illness narrative?
b. Describe the process of writing. Did anything surprise you?
c. What did you feel when writing the illness narrative?
d. What did you learn from writing this illness narrative? About yourself? About illness and healing in general? What did you learn through writing about this illness experience that you did not know before?

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