Seabrook, Abigail, Killick, Steve, Parish, Nicole, Underwood-Lee, Emily and Waters, Cerith S. 2023. Important factors in storytelling interventions for families affected by cancer: a Delphi study. Storytelling, Self, Society 19 (2) , pp. 121-159. 10.1353/sss.2023.a979127

Publishers page: https://doi.org/10.1353/sss.2023.a979127

Important Factors in Storytelling Interventions for Families Affected by Cancer

A Delphi Study

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The current study represents the first stage in the development of a storytelling intervention to promote psychological well-being for families affected by cancer. A two-round Delphi study was used with the aim of establishing consensus and exploring the diversity of opinion of three groups of experts: professional storytellers, health-care professionals, and experts-by-experience (N = 25). A list of 73 summary statements was generated from round one interviews. Of these statements, 91.6 percent achieved consensus. Main areas of consensus included flexibility of format and content, the need for psychological support, and psychological safety. Items that did not achieve consensus were explored further. Implications and avenues for future research are discussed.

Key words: Delphi study, cancer, family, mental health, well-being, storytelling

Cancer significantly disrupts family systems, often leading to psychological distress among caregivers, partners, and children. Storytelling, a universal human practice, has shown therapeutic potential in health care by facilitating emotional expression, meaning-making, and interpersonal connection. This study explores the development of a storytelling intervention to support families affected by cancer, using the Delphi method to establish consensus among key stakeholders.

Cancer and the Impact on the Family

A diagnosis of cancer affects the family system, with family members affected by increased demands and stressors, and if not managed, long-term disruption to the family could result (Campbell-Enns & Woodgate, 2015). Regardless of their socioeconomic background, family caregivers have reported experiencing intense symptoms of anxiety and depression, along with a diminished quality of life during the home care period and postdeath (Götze et al., 2018).

Although most family caregivers adjust, many report considerable psychological distress, with contributing factors affecting their own health problems depending on levels of support (Chen et al., 2013). Distress increases with progression of the illness (Morse & Fife, 1998), with increasing levels of depression coinciding with time spent caring and reduced daily functioning (Teixeira et al., 2019). Partners of cancer patients face particular challenges, such as worry about their partner's death and their ability to support the family (Manne & Badr, 2008) and changes in family or occupational roles such as managing household responsibilities and child care (Gray et al., 2000).

Posttraumatic symptoms in children of cancer patients can be precipitated (Egberts et al., 2022). Patients who are also parents with school-age children experience higher levels of anxiety and depression (Ernst et al., 2013). Greater anxiety in parents may influence parenting, which may in turn affect children's anxiety (Huizinga et al., 2011). Parents of children with cancer often experience increased levels of distress, which may persist for many years after diagnosis (Boman et al., 2003). Similarly, siblings of children with cancer may also experience increased symptoms of trauma, anxiety, and depression (Gerhardt et al., 2013). The use of active problem-solving and reductions in avoidance behaviors can reduce anxiety and depression in parents of child cancer patients (Norberg et al., 2005). Good communication within a family and a supportive environment can be important protective factors for children with a family member with a cancer diagnosis (Migliaccio et al., 2024).

Storytelling

Although storytelling is most often associated with live oral delivery, either from memory or via written media, storytelling can also take the form of audiovisual recording, visual media, and online platforms (Drumm, 2013; Palacios et al., 2015). As storytelling is universal to human cultures, some authors theorize that storytelling has an adaptive role and enables humans to benefit from the experience of others without having to expose themselves to similarly dangerous situations (Sugiyama, 2001). Robin Mello (2001) identifies a process of "negotiated transaction" whereby humans can compare their own understanding and experience to those of the storyteller.

Storytelling and Health Care

Storytelling has various applications within health-care contexts, including practitioner learning and capturing and communicating patients' experiences. The current study is focused on the therapeutic benefits of storytelling for patients and families. Storytelling as a therapeutic tool developed from ancient traditions of healing and greater understanding of the self (Haigh & Hardy, 2010). The humanistic psychology movement emphasized the importance of narratives unique to the individual, standing in contrast to behaviorism and psychoanalysis. Roberts (2000) describes how Michael White and David Epston drew on this previous history to develop narrative therapy as a way of revising a client's relationship with "problem-saturated" narratives. Despite the humanistic psychology movement's opposition to behaviorism and psychoanalysis, stories play an important role in psychoanalysis and cognitive therapies. Bruno Bettelheim (1976) took a psychoanalytic approach, influencing early research into storytelling as a psychotherapeutic intervention (Tucker, 1984). Cognitive-behavioral therapies also use storytelling and metaphor (Roberts, 2000). Metaphor is also used in acceptance and commitment therapy (ACT) and dialectical behavior therapy (DBT) (Killick et al., 2016).

Sue Heiney's (1995) model of storytelling posits that the therapeutic effects of storytelling are procured in four domains: *cognitive* (imparting knowledge, improving learning, and helping problem-solving), *affective* (hope, catharsis, and normalization in response to a character's experiences), *interpersonal* (communication, facilitating common purpose), and *personal* (improved confidence, self-esteem, mastery, and finding meaning).

Stories can help an individual organize their thoughts and feelings, enabling them to recognize patterns and relationships. Stories externalize problems, which may help to overcome defensiveness and resistance. Stories are often remembered where the content of a therapeutic session may not be, enabling a means of communication between client and therapist, who may be able to recapture the therapeutic message by using a key word or phrase from the story (Bergner, 2007).

Storytelling and Cancer Care

The evidence base for the use of storytelling interventions in the context of cancer care is emerging. Andrew Soundy and Kate Reid (2019) reviewed the impact of storytelling interventions for cancer patients, finding consistent evidence that storytelling interventions were beneficial for this group in helping with emotional expression and the ability to reappraise circumstances. Positive outcomes of storytelling interventions included psychological healing, shared understandings of coping, well-being, and a rationalization of the illness experience. Soundy and Reid theorized that interventions derived their benefit by increasing levels of trust between patients and health-care professionals and strengthening communities. Jane Chelf et al. (2000) reported that 97% of participants agreed that storytelling was helpful and 85% felt that the stories gave them hope. In child cancer patients, storytelling has been shown to help families deal with the stress associated with hospitalization (Brockington et al., 2021), promoting better emotional coping (Cho et al., 2023).

There are many possibilities for delivery of storytelling that may be considered, such as oral storytelling and bibliotherapy. Previous interventions have used digital stories (De Vecchi et al., 2016), scrapbooking (McCarthy & Sebaugh, 2011) and creating stories (Redshaw et al., 2011). After the COVID-19 pandemic, interventions were adapted for online delivery, which was found to be accessible and acceptable (Zhong et al., 2023). Online delivery offers opportunities for patients who need to self-isolate due to immune system suppression.

The current study aims to develop a storytelling intervention that promotes the psychological well-being of families affected by cancer. The Delphi method was used to define important elements of an intervention and establish consensus among different stakeholder groups, including professional storytellers, health-care professionals who have experience working in cancer care, and people who have been affected by their own, or a family member's, cancer. The Delphi method's emphasis on consensus has been criticized for excluding information with little consensus but still may have value (Donohoe & Needham, 2009). Therefore, this study also explored diversity of opinion where consensus was not achieved.

Method

This study used a mixed-method Delphi design to explore expert perspectives on storytelling in cancer care. Round One involved semistructured interviews to gather qualitative data, followed by a survey in Round Two to assess consensus and diversity of opinion. Ethical approval was granted by Cardiff University's School of Psychology Research Ethics Committee, and all participants provided informed consent. Anonymity and the right to withdraw were ensured throughout.

This study followed CREDES guidance (Conducting and Reporting Delphi Studies in Palliative Care), an outline of components that should be reported in studies related to health (Jünger et al., 2017).

Design

The Delphi method is a research technique whereby experts give their opinions anonymously on a given topic with the aim being to create consensus between participants and explore differences of opinion. This study uses a mixed-method approach, with qualitative data gained through a round of semistructured interviews followed by a survey. All participants were given information about the study and the opportunity to ask questions. Participants were required to sign a consent form to participate.

Participants

This study recruited adult participants from three expert groups in the field of storytelling and cancer care:

- storytellers who identify as professional or semiprofessional storytellers with experience of delivering storytelling interventions with cancer patients,
- health-care professionals with experience in cancer care, and
- people with lived experience of their own, or a family member's treatment of cancer.

In practice, there was some overlap between these groups, several members of the storytelling or health-care professional groups recounted their own experience of cancer diagnosis and treatment. Demographic information for each group is shown in Table 1. Recruitment took place primarily within the UK aiming to recruit 10–15 participants, the recommended sample size for Delphi studies (Skulmoski.)

Participants for Round One were identified through existing contacts, social media, and advertisement in a cancer charity newsletter. Individuals were invited to participate via email, and further recruitment occurred as participants were asked to recommend others that met the inclusion criteria. Of the 24 contacts who fulfilled inclusion criteria and were contacted for the initial round, 15 responded and participated.

For Round Two, participants invited to complete the survey included all of those who completed the Round One interview (n = 15), and an additional 14 participants were recruited using the same methods as the first round. The recruitment of additional participants for Round Two followed the same methods as Round One and included storytellers, health-care professionals, and experts-by-experience. All participants were aged between 40 and 75.

Procedure

The study used a qualitative method for the first round to gather rich data on the breadth of expert opinion. The main subject areas to be covered, for example intervention format or types of stories, were discussed, and an interview schedule was drafted and piloted within the research team. This refined the interview schedule. Storytellers and health-care professionals were asked additional questions about their roles and experience in their role or practice, and basic demographic questions were added.

Round One interviews were arranged and conducted by the primary author, over an online platform. Interviews were transcribed and imported into the NVivo-12 qualitative software package for data analysis. Conventional content analysis, as described by Hsui-Fang Hsieh and Sarah Shannon (2005), was used to analyze interviews and create summary statements. These were presented as survey items using a 5-item Likert scale indicating level of agreement where “1” equaled “strongly disagree” and “5” equaled “strongly agree,” plus questions regarding demographic data. The survey was distributed to Round Two participants via an email with a personal link to the study. The study aimed to explore diversity of opinion as well as areas of consensus, and so two rounds were deemed sufficient.

Round Two survey results were imported into SPSS (Version 29.0.2.0) for analysis. Descriptive statistics including the mean, standard deviation, maximum and minimum ranges, and interquartile range (IQR) for each item were calculated.

The Cardiff University ethics committee granted approval prior to recruitment. Unlike other consensus methods, the Delphi method is characterized by anonymity, as participants do not meet one another and feedback on previous rounds is disseminated anonymously (Barrett & Heale, 2020). The subject matter of the current study had the potential to cause distress to participants. This risk was acknowledged in the participant information sheet. Contact details for the primary author were provided and participants were encouraged to get in touch if they felt distressed following the interview. Contact details of relevant mental health organizations were also provided.

Reflexivity

The primary author reflected on their assumptions about storytelling and the role that it could play in the reduction of psychological distress in families affected by cancer. As a British, mixed-heritage, female, neurodivergent clinical psychology trainee, the primary author was most familiar with Westernized storytelling traditions. The author also had professional experience in the creative industries and performance as well as experience working with second- and third-wave cognitive therapeutic approaches. These factors may have influenced the conducting of interviews and qualitative analysis of data. To counter this, the primary author maintained an awareness of their own biases and attempted to approach the interview process with openness and encouragement of criticism of the interview questions.

Results

As the current study involves the design of a therapeutic storytelling intervention and two overlapping samples of participants, to avoid confusion the following terms will be used: Round One study participants will be referred to as “interviewees”; study participants that took part in Round Two will be referred to as “survey respondents”; participants in a storytelling intervention referred to by interviewees or survey respondents will be referred to as “patients/service users.”

Round One: Semistructured Interviews

Six main categories with subsequent subcategories were identified through analysis of the interviews with N = 15 participants: Intervention Quality; Psychological Need; Helpful Stories; Processes by Which Stories Help: Desired Outcomes of Intervention; and Psychological Safety. These are summarized in Table 2.

Intervention Quality

This category looked at the practical aspects of an intervention and their importance to ensuring that the intervention fulfills its aims. The subcategory that received the most cited responses related to inclusion and the factors that affected it, such as the involvement of family members. The role of session format, whether online or face-to-face, was important, with all interviewees but one citing the need for an intervention to be tailored to the needs of the target audience. Flexibility in terms of format and content was also deemed important to maximize engagement. Frequent references were made to the skills of intervention facilitators, such as reflexivity toward their audience.

Psychological Need

This category described the psychological needs of families. A metaphor that was often cited in the subcategory of *fear* was of *feeling lost*, relating to uncertainty and fear associated with a cancer journey. It was closely followed in frequency by the loss of an imagined future. Instrumentalism, or the idea that the stories would have an explicit agenda, featured heavily in the subcategory *I am more than my cancer*, and related to interviewees' feeling that cancer patients' identity could become defined by their cancer. The changing of roles within the family was the most featured code within the subcategory *effect on family* and described how families could struggle to adjust to the changing roles that a cancer diagnosis often demanded. Also relevant to interviewees was the need for agency, or sense of control.

Helpful Stories

It is important to determine what kinds of stories families might find most helpful. Both fictional and biographical stories were mentioned as being helpful; 12 interviewees discussed the ability of the listener to relate to a story's protagonists as being important. An element of familiarity within a story was also cited as being important, perhaps to assist relatability. Six interviewees felt that different types of stories could be employed to meet different needs within the audience.

Processes by Which Stories Help

Interviewees identified several processes by which a storytelling intervention could help to reduce psychological distress. Social factors were the most prevalent, and these included the importance of connecting socially and developing an understanding that could be shared with others in a similar situation. An important process highlighted in the data was the potential for families to create a more positive alternative for an imagined future since the cancer diagnosis. It was felt that this could be achieved by a storytelling intervention enabling a change in perspective, perhaps through identification with the story's protagonists. Making-meaning was part of that process. Also important to the reduction of psychological distress was the taking part in an activity that could be enjoyed for its own sake.

Desired Outcomes of Intervention

Interviewees held fewer opinions on questions relating to outcomes and their measurement, with only 11 out of 15 interviewees giving a clear answer. The difficulty of measuring outcomes in a storytelling intervention was highlighted, with some suggesting that families could be asked for feedback or changes in their appearance or demeanor observed by facilitators.

Psychological Safety

Organizations running the intervention were deemed to be responsible for ensuring the psychological safety of patients/service users and facilitators. This could be through enabling access to supervision for facilitators or creating a mix of skills between facilitators from which patients/service users participating in the intervention could benefit. Some interviewees highlighted the importance of having a health-care professional present as well as a storyteller to answer questions about cancer or to help a participant who was struggling emotionally. The importance of facilitators having skills in running group interventions was also mentioned by interviewees, with facilitators having the opportunity to access training in skills such as safeguarding and setting group boundaries.

Round Two: Consensus Survey

Summary statements were created by expressing codes as statements that could be answered on a 5-item Likert scale ranging from "strongly disagree" (1) to "strongly agree" (5). Survey statements were discussed within the research team, and in some cases, statements were merged into new statements or the wording clarified. The statements were transferred to an online survey using the Qualtrics online survey platform, which incorporated respondent information, consent form, demographic questions, and questions that captured group membership and length of experience. All Round One interviewees were invited to participate in Round Two; of these, 10 out of 15 completed the Round Two survey, giving a retention rate of 66.67%. Of the original interviewees who did not complete the Round Two survey, two were storytellers and three were experts-by-experience. A further 14 participants were contacted, of which 10 completed the Round Two survey (response rate 64.23%), these consisted of five experts-by-experience: three health-care professionals and two storytellers. One participant completed the survey without answering all questions. The total response rate for Round Two was 65.51%.

Summary statements and results are presented in Table 3. Sixty-six (91.6%) items achieved an IQR of equal or less than one, indicating consensus. To examine consensus further, the percentage of survey respondents who scored within two adjacent responses on the Likert scale is presented in the "percentage consensus" column. This last measure of consensus has been used by authors such as Sally Pezaro and Wendy Clyne (2016) and Jill Domoney et al. (2020). There was strong consensus in several key aspects of a possible storytelling intervention for families affected by cancer. Respondents considered that flexibility in terms of format and content is crucial for engagement and that, as well as medical treatment, cancer patients and their families need psychological and emotional support. Other important areas of consensus included coproduction to address diverse needs and the importance of facilitators to have strong storytelling skills and training to ensure psychological safety. Also important for respondents was the consideration of practical factors such as time, energy, and resources. There was a lack of consensus on the involvement of family members, the effectiveness of online versus face-to-face delivery, and the relevance of true-life versus fictional stories for families affected by cancer.

Discussion

This Delphi study aimed to examine consensus on the components and design of a storytelling intervention to promote psychological well-being in families affected by cancer. A wide range of practical and psychological factors were identified by 15 interviewees in Round One, and of the 73 items included in the Round Two survey, 91.6% reached consensus with survey respondents. A response rate of 62.5% was achieved for Round One and a total response rate of 65.51% for Round Two. Each survey question fell under one of the following categories:

Impact on Families/Involvement of Family Members

Looking at the impact of a cancer diagnosis and treatment on families, survey respondents agreed that the loss of a loved one was a common fear for family members. All survey respondents felt that other family members' needs could go unmet and that they should receive support. However, in the section about involving families in the intervention, there was lower support for family members necessarily being involved in a storytelling intervention. Survey respondents thought that a storytelling intervention designed for families might have different objectives than one designed for the individual. This could be interpreted to mean that survey respondents felt that different interventions could be created for family members and individual patients. Laing et al. (2019) found that adult cancer survivors found it difficult to fully express their feelings out of a desire to protect family members. However, studies have found that storytelling interventions can promote communication and enable difficult conversations between family members (Akard et al., 2020; Laing et al., 2019).

Psychological Need

In terms of psychological need, the item regarding loss of the imagined future was the most controversial, with answers ranging from strongly disagree to strongly agree. However, this item had an IQR of 1 and a mean of 4.37, indicating consensus of agreement. The role of hope and problem-solving is outlined in Heiney's (1995) theory of storytelling, suggesting that a storytelling intervention could potentially address this loss. Survey respondents felt most strongly about the need for community support for families and that emotional support should be received in addition to medical treatment. The importance of community support for people with advanced cancer and their families in a rural setting was explored by Wendy Duggleby et al. (2011), who found that participants felt both supported and isolated by their changing role within their community. Soundy & Reid (2019) identified community cohesion as a benefit of storytelling interventions as well as the role of interaction and shared understanding. These results underscore the importance to survey respondents of emotional and community support that could be considered when developing an intervention.

Tailoring of the Intervention

Survey respondents unanimously agreed that flexibility in terms of format and content of the storytelling intervention can promote engagement. There was also strong agreement that coproduction of the format and structure of the intervention could be employed to consider the particular needs of patients/service users. The coproduction of mental health interventions can help to ensure that those interventions align with the needs of patients/service users (Dent, 2019). Coproduction can also address power differentials through the valuing of the expertise and knowledge of experts-by-experience (Slay & Stephens, 2013), which may address the need of people affected by cancer for greater control and agency, identified in Round One.

Study participants did not agree that an intervention with an obvious agenda could lead to participant disengagement. As survey respondents agreed that it was important for patients/service users to know what to expect from an intervention, it is likely that some survey respondents felt that an obvious agenda might promote psychological safety. This is consistent with Round One in which the idea of a story having an obvious agenda seemed controversial. In Round One, storytellers mostly rejected the idea, and health-care workers were more likely to support it. However, the Round Two survey suggests that much of the disagreement came from experts-by-experience, whose answers ranged from “somewhat disagree” to “strongly agree.” No respondent in the other groups disagreed with the statement, although some of the storytellers were neutral. With hindsight, it may have been beneficial to have this reflected in a separate question regarding the kind of stories that might be helpful, to differentiate it from an obvious agenda to the intervention as a whole.

Delivery of the Intervention

Five sections pertained to the practical aspects of intervention delivery: duration of the intervention and frequency of sessions, session duration, online versus face-to-face delivery, individual versus group format, and including additional relaxation techniques such as meditation or mindfulness as part of the sessions. Regarding the length of the intervention, survey respondents generally neither agreed nor disagreed that six weeks was a good duration for an intervention; there was also little strength of feeling regarding the intervention having a regular weekly format to promote the building of relationships. This is perhaps not surprising, given the consensus around the flexibility of a storytelling intervention outlined above. However, it should be noted that responses to the item regarding the regular weekly format covered the range of the scale, with at least some survey respondents having a strong agreement or disagreement with this item.

In terms of session duration, all items achieved consensus, with the consensus being “neither agree nor disagree” to sessions being 45 minutes to one hour in duration, or a maximum of two hours. Survey respondents did not necessarily feel that patients/service users would benefit more from a longer session, lasting a few hours at a time. Survey respondents did feel strongly that when deciding the length of sessions, there were many factors to consider, such as the format of sessions and characteristics of the patients/service users.

Considering online and face-to-face delivery, survey respondents seemed to feel that there were pros and cons of both. It was generally felt that although online delivery could be a barrier to patients/service users building connection with one another, it would make the intervention easier for some patients/service users to access. Consensus was not achieved for the statement, “A storytelling intervention that is online/partially online can work as well as one that is face to face,” with responses ranging from strongly disagree to somewhat agree. Storytellers and experts-by-experience were the most likely to disagree, with responses ranging from “strongly disagree” to “somewhat agree” and a mean of 2.67. Health-care professionals had more neutral opinions, ranging from “somewhat disagree” to “somewhat agree” and a mean of 3. These findings echo those of Haim Weinberg (2021), who found that although online group psychotherapy could be effective, the format presented challenges, including the slower formation of group cohesion. A practical implication of this may be that the decision to include online delivery will depend on the resources and circumstances of the facilitators and patients/service users involved in the intervention. However, given the importance of the social aspects of storytelling interventions (Heiney, 1995; Soundy & Reid, 2019), methods of promoting social connection using online delivery should be considered.

Again, survey respondents acknowledged costs and benefits of working with individuals or individual families rather than large groups. It was felt that social connection would be easier to improve using a group format, but that working with individuals or individual families would benefit from greater flexibility in terms of session delivery. When asked about the inclusion of additional relaxation techniques such as meditation or mindfulness as part of the sessions, there was consensus that, although a storytelling intervention was relaxing, including additional relaxation techniques could be beneficial. Although a range of responses were present, no respondent strongly disagreed with the items described above.

Types of Stories That Might Be Helpful to People with Cancer and Their Families

Responses to this topic were among the most diverse. No item achieved an IQR of 0, although all but one achieved an IQR of 1. The least consensus was shown regarding the types of stories that might be relevant to families affected by cancer, such as true-life stories and fantasy/fiction stories. There was a low percentage consensus for the statement, “True-life stories are more relevant to families affected by cancer than fantasy/fiction stories.” For this item, responses covered the full range and had an IQR of 2. Storytellers tended toward neutrality or disagreement, with a mean of 2.5, and none agreed or disagreed strongly. Health-care professionals responded with a mean of 3; however, this group’s responses covered the whole range, indicating lower consensus. Experts-by-experience tended toward agreement, with a mean of 3.65, but like the storytellers, none agreed or disagreed strongly.

There was greater consensus regarding the elements of helpful stories. Survey respondents agreed that a helpful story should contain elements of familiarity and relatability to offer comfort and to assist identification with the protagonists or the situation. Identification is an important process in the ability of a story to communicate ideas and change beliefs (Oatley, 1999). A helpful story was also considered to be one that would contain an element of unfamiliarity to allow the listener to arrive at their own interpretation and offer escapism. The survey respondents mostly agreed that a helpful story would contain enough flexibility to change in order to meet the needs of patients/service users. The modeling of flexibility using stories in therapy has been identified by authors such as Burns (2000) and is consistent with Bergner’s theory that stories allow listeners to consider and respond to thoughts and feelings in a more flexible way. These findings could assist storytellers in selecting stories that might be included in a storytelling intervention.

Processes by Which a Storytelling Intervention Could Help People with Cancer and Their Families to Meet Their Psychological Needs

When thinking about the processes by which a storytelling intervention might achieve a reduction in psychological distress, there was the greatest support for acceptance of difficult thoughts and feelings, the normalization of experiences and validation of feelings, and connection with others who have had similar experiences, which may also help to normalize and validate. This is consistent with Heiney's theory about the power of story to promote normalization and the transfer of knowledge as well as a connection between the listener's experiences and higher truths.

There was less agreement that stories could help patients/service users to create a more positive vision of the future, as this had an IQR of 2. This may reflect a rejection of instrumentalism or "toxic positivity." Toxic positivity is a term that refers to the unhelpful minimization of negative feelings via suppression, often on the advice of others (Upadhyay et al., 2022). This finding may be consistent with the finding that validation of feelings is important. There may also have been a sense that a positive vision of the future might not be realistic in all cases. This statement may have benefited from greater clarity as to what the term "positive" could encompass, perhaps in terms of greater acceptance or emotional resilience.

Desired Outcomes of a Storytelling Intervention, and How These Could Be Measured

All items under this heading achieved consensus, with all survey respondents agreeing that outcomes could be measured by asking patients/service users for their feedback directly. The statement that the storytelling intervention should be realistic in its aims achieved an IQR of 0 and the highest mean agreement, again, possibly indicating a rejection of toxic positivity. The lowest level on consensus and agreement was found for the statement, "The outcomes of a storytelling intervention could be measured by observing participants' behavior or presentation," indicating that at least some survey respondents felt that this method would be inadequate.

Psychological Safety and Harm Prevention in a Storytelling Intervention

Items under this heading received a very high level of consensus, with all items achieving an IQR of 0. This indicates the importance to survey respondents of psychological safety in an intervention. Survey respondents were in unanimous and strong agreement that facilitators should have the skills needed to promote psychological safety and should undertake training if necessary. In addition, all survey respondents agreed that facilitators need to understand their responsibilities with regard to their own or others' psychological safety. Responsibility was not limited to the facilitators. Survey respondents felt that the organization running the intervention, and the patients/service users themselves, also bore responsibility for ensuring psychological safety. This may be through providing appropriate resources such as supervision for facilitators, or patients/service users sharing expectations of the intervention with one another, possibly through the use of a group contract. Coproduction could also play a role in fostering psychological safety (Bell et al., 2023).

Limitations

There were several limitations to this study. Uncommonly for a Delphi study, experts were drawn from three distinct groups, one of which was experts-by-experience. The inclusion of this experts-by-experience group could lead to questions being asked of their expertise, likewise the expertise of health professionals could be asked about a storytelling intervention. However, the contribution of experts-by-experience is increasingly valued in Delphi studies (Law & Morrison, 2014; Seery et al., 2022), and there is growing recognition that stakeholders should be involved in the development of interventions (Racine et al., 2022). The researchers felt that inclusion of these groups was essential to the validity of any conclusions drawn from the results. Prior experience of storytelling interventions was not part of the inclusion criteria, which may limit any conclusions drawn from the results. However, a high level of consensus was reached in the study, which included participants with considerable experience in storytelling interventions as well as their own cancer experiences. It is generally considered that a homogeneous panel of participants achieves consensus more easily and does so with fewer rounds (Hammond et al., 2018; Skulmoski et al., 2007). The fact that a high level of consensus was reached in only two rounds in the current study indicates that limiting recruitment to those with experience in a storytelling intervention would be unlikely to significantly affect the results.

It has been argued that the small samples used in Delphi studies may not be representative of experts on a given topic (Niederberger & Spranger, 2020). Splitting the sample between three groups of experts would have reduced the sample size from each group, possibly leading to an even smaller level of representation. However, it has also been argued that samples over 15 tend not to add value to a consensus study (Freitas et al., 2016), and the recruitment, interviewing, and analysis of the data produced by a larger sample would have had an impact on the available resources of the research team. Furthermore, a diverse panel is likely to achieve a broader perspective (Nasa et al., 2021), which aligns with the aims of the study. There are further issues of generalizability presented by the demographic makeup of the sample. Experts tended to be older and predominantly from a white ethnic background, meaning that results may not generalize to storytelling interventions aimed at patients/service users from minoritized ethnic groups, or younger patients/service users. Possible avenues for further research might be to explore consensus among children, young people, and young adults affected by cancer as well as among storytellers from different cultural backgrounds.

The current study contained only two rounds, meaning that experts were unable to change their responses after reading the responses of others in line with classic Delphi methods. However, Round Two items achieved a high level of consensus at 91.6%, while many Delphi studies achieve 51% to 80% (Chuenjitwongsa, 2017). It is therefore unclear what would be gained by the inclusion of further rounds, even if the aim of the study was to achieve consensus.

Facilitator Implications

This study has implications for facilitators of storytelling interventions who aim to promote psychological well-being in families affected by cancer. It is encouraging that there was a high level of consensus between the three groups, indicating that many elements presented to survey respondents would also be acceptable to various stakeholders, although care needs to be taken in the light of some items that received a range of responses. The findings around flexibility and tailoring of the intervention lend support to the concept of coproduction between stakeholders (Bell et al., 2023) which may promote greater acceptability and accessibility. There are also clear recommendations for the promotion and importance of psychological safety in an intervention, especially regarding the role of facilitators. The findings of this study could help to inform future project development or help artists and health professionals to design interventions that could then be evaluated further. Another practical application would be the creation of best-practice guidance materials for facilitators of a future intervention.

Research Implications

Delphi studies usually measure consensus; however, the exploration of items that did not achieve consensus was interesting and suggests avenues for future research. Some possibilities are the investigation of effectiveness of online versus face-to-face delivery, or the effectiveness of different types of stories whether real-life or fictional, and how these might influence the development of coping strategies or engagement with the intervention.

The Delphi method has emerged over the last six decades as a method for establishing consensus on a given topic (Barrett & Heale, 2020). However, there is a little agreement on how consensus is measured (von der Gracht, 2012) with some studies using IQR and some studies using descriptive statistics and percentage consensus. This study found value in using both to further explore and interpret results. The researcher found that a single measure of consensus could obscure variation in expert opinion, which could have implications for the interpretation of results. Further studies on the measurement of consensus or the exploration of diversity of opinion are warranted.

Conclusion

The current study aimed to explore consensus and diversity of opinion with a view to informing the development of a storytelling intervention aimed at families affected by cancer. The study achieved a high level of consensus, which may provide valuable guidance to developers and facilitators of storytelling interventions as to the key components that are important in such an intervention, such as flexibility and coproduction. Other prominent findings were the need for facilitators to have strong storytelling skills and training to ensure psychological safety. The findings will assist in the development of interventions that are effective and acceptable to patients/service users as well as highlight the need for service user groups to be involved in the design process. These findings suggest the following best practices:

Family Involvement and Impact

- Acknowledge the emotional burden on family members and ensure their support needs are met.
- Consider separate interventions for patients and families, as objectives may differ.
- Use storytelling to facilitate difficult family conversations, while being sensitive to family dynamics.

Psychological Needs

- Address loss of the imagined future through interventions that support hope, problem-solving, and acceptance.
- Prioritize emotional and community support alongside medical care, particularly in rural settings.
- Design interventions to foster connection, validation, and normalization.

Tailoring the Intervention

- Ensure flexibility in format, content, and delivery to meet diverse needs.
- Involve patients/service users in coproducing the intervention to enhance relevance and agency.
- Clearly communicate intervention aims to promote psychological safety.

Delivery Considerations

- Allow for flexible session duration and scheduling.
- Consider pros and cons of online versus face-to-face delivery; online access may reduce connection but improve accessibility.
- Offer both group and individual formats based on context and goals.
- Consider incorporating additional relaxation techniques where appropriate.

Story Content and Structure

- Include a range of story types (e.g., true-life, fiction) to reflect varied preferences.
- Use stories that balance familiarity (for comfort) and novelty (for interpretation).
- prioritize flexible stories that can be adapted to user needs.

Mechanisms of Impact

- Focus on storytelling processes that promote acceptance, validation, and connection.
- Be cautious of overemphasizing “positivity”; realism and emotional honesty are valued.

Outcome Measurement

- Collect direct feedback from participants as the primary measure of success.
- Set realistic aims and avoid relying solely on observable behaviors for evaluation.

Psychological Safety

- Ensure facilitators are trained to maintain psychological safety.
- Share responsibility for safety across facilitators, participants, and organizations.
- Use tools like supervision, coproduction, and group agreements to support safe environments.

Abigail Seabrook recently completed her doctorate in Clinical Psychology at Cardiff University. Her research interests include the psychological benefits of storytelling, climate anxiety, and psychological impacts of neurodivergence. She is passionate about integrating creative and inclusive approaches into mental health practice and community-based psychological support.

Steve Killick is a clinical psychologist in independent practice and also works as a storyteller. He has developed (with Phil Okwedy) "Feelings Are Funny Things"—a storytelling intervention for schools to develop well-being and emotional literacy. He has written (with Taffy Thomas) "Telling Tales—Storytelling as Emotional Literacy" among other publications, including being project lead for the British Association of Behavioural and Cognitive Therapies publication *Changing the Climate Conversation: A CBT approach to addressing the crisis*. He is a visiting fellow at the George Ewart Evans Centre for Storytelling, University of Wales, Cardiff.

Nicole Parish is the systemic practice lead for the South Wales Doctorate in Clinical Psychology, alongside her role as a principal clinical psychologist at Noah's Ark Children's Hospital for Wales. She works systemically with children with medical conditions and their families and is particularly interested in how compassion-focused approaches can support both patients and health-care staff.

Emily Underwood-Lee is a professor of performance studies at the University of South Wales and codirector of the Centre for Storytelling. Her work focuses on amplifying little-heard personal stories from people whose voices may have been overlooked and from the difference that hearing these stories can make in policy, practice, and daily life for both teller and listener. She has a particular interest in stories of the maternal, gender, health/illness, and heritage. Her research focuses on contemporary feminist performance, autobiographical performance, and first-person narratives. She cochairs the VAWDASV Research Network Wales and leads the Arts Health and Wellbeing group within the Wales Innovation Network, promoting cross-sector collaboration across Welsh universities.

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