

Chapter 1

Expanding the Gates of Perception

Christopher Johns

Aldous Huxley (1959) reflected on his experience of taking mescaline and its impact in enabling him to access the greater 'mind at large' and in doing so to circumvent the brain and nervous system as some sort of reducing valve. In other words, taking mescaline blew fuses and opened Huxley's mind to perceive things in new and different ways. Hence the title of his book, *The Doors of Perception*. As we go about our everyday business we take the world largely for granted and respond habitually. Meaning is projected into events that enable us to take things in our stride, and in doing so, reinforce our sense of self. Thus the multiple doors of possibility are not always visible: instead, existing knowledge and experience are defended as if the ego itself is threatened. The more we know, the more threatened we become when that knowing is challenged. A certain degree of anxiety and fear is useful for learning (see Joyce 1984; Casement 1985; Freshwater 2000). However, too much fear and anxiety is not conducive to learning. Perhaps we all need mescaline in the morning to heighten our perceptions, to lower our defences and open ourselves to possibility.

From a Buddhist perspective we are caught in a world of *samsara*, depicted by the cock, the snake and the pig – craving, aversion and delusion respectively – who chase one another around and around, locked into a world of greed, hate and ignorance. It is a restless world of seeking pleasure to avoid pain: what Freshwater (2003) refers to as 'toxic speed sickness'. We cling to what we know, for the small pleasures that we have, lest we lose even them. Yet, as Huxley (1959, p. 55) notes: 'the urge to transcend self-conscious selfhood is, as I have said, a principal appetite of the soul'. This message is reinforced by transpersonal philosophers such as Ken Wilber (1996) who makes a compelling argument that the goal of human evolution is to transcend self through increasingly higher levels of consciousness. Margaret Newman (1994), drawing on diverse theorists such as Young (1976) and Prigogine (1980), suggests that the role of nursing is to guide people (requiring health care) to grow through the health-illness experience towards higher levels of consciousness. She uses examples of people experiencing life-threatening illness and its impact in finding new, more positive meaning to life. In order for nurses to assist others through the process of expanding consciousness, they too need to be aware of their own need to work at differing levels of consciousness. Buddhists have struggled with such questions for a lifetime. The Buddhist path, it is argued, is a way to free self and others from this endless suffering and misery in order to realise our human potential and

destiny. Perhaps mescaline can bypass the effort required to break free of conditioned existence but it is yet another form of avoidance, it is addictive, its effects are short-lived and, of course, it is illegal. So much for mescaline! Nevertheless, Huxley's message is clear: there is a mind at large that few of us rarely tap into that opens up possibilities for human growth. And herein lies the further *potential* of reflection. This potential is highlighted because I suspect that is not people's general perception of reflection. The aim here is to open the doors of your perception to reflection and its possibilities. If you want to slam the door shut on all this heady nonsense, ask yourself why. But in doing so, consider the words of Beckett (1969, p. 169):

To be capable of helping others to become all they are capable of becoming we must first fulfil that commitment to ourselves.

I have always been drawn to Beckett's words simply because they offer a profound challenge to each of us who purport to care. The fulfilment of this responsibility must be the hallmark of professional practice. However, this is not necessarily easy work. Many nursing authors have taken up Beckett's challenge, turning the reflective gaze inwards towards self-transformation, self-care and self-reflection. Nevertheless, there continues to be a struggle against reflective practice, amid the belief that it is self-indulgent, narcissistic and selfish. This tells us something not only about the culture and context, but also about the way in which we relate to the self and to the ego (which tends to get a raw deal).

Describing (defining) reflection

The reflective traveller is faced with an array of definitions and models as possible guides. I have been developing my own description of reflection over many years. As a reflective practitioner, I constantly seek better forms of representation in light of new experience and insights. Hence description is preferable to definition, because definition implies an authority that I feel would be misplaced with regard to the idea of reflection.

Reflection is being mindful of self, either within or after experience, as if a window through which the practitioner can view and focus self within the context of a particular experience, in order to confront, understand and move toward resolving contradiction between one's vision and actual practice. Through the conflict of contradiction, the commitment to realise one's vision, and understanding why things are as they are, the practitioner can gain new insights into self and be empowered to respond more congruently in future situations within a reflexive spiral towards developing practical wisdom and realising one's vision as a lived reality. The practitioner may require guidance to overcome resistance or to be empowered to act on understanding.

(Johns 2004a, p. 3)

From this description, reflection is both subjective and particular. It is a fusion of sensing, perceiving, intuiting and thinking related to a specific

experience in order to develop insights into self and practice. It is vision-driven, concerned with taking action towards knowing and realising desirable practice. In doing so, it intends to resolve contradiction so that people can lead more meaningful lives. In other words reflection is purposeful.

Attempts, including my own, to 'know' reflection are essentially an intellectual effort to grasp something as if it had some sort of objective reality: a point of reference so that everyone would know exactly what it was. Such is the Newtonian nature of science: to know and control things. Perhaps as a technique reflection can be known, although the plethora of definitions and models indicates little intellectual consensus. Indeed, the diversity of opinions suggests that intellectual effort to know reflection is subjective. Reflection cannot be grasped because reflection *is* essentially a way of being in the world that is intuitive and holistic. Hence, by its very nature, it cannot be reduced into a neat conceptual analysis.

The practitioner reading this description of reflection, or in fact any other definition of reflection, is faced with interpreting the words into action. Put another way, how do you 'do' reflection? In response, theorists have constructed elaborate models to guide the practitioner into the mystery of doing reflection. Indeed I have contributed to this field with my own Model for Structured Reflection (MSR) that I constructed and have constantly tested and refined (Box 1.1). The ways of knowing shown against each cue in Box 1.1

Box 1.1 Model for structured reflection – 14th edition (Johns 2004a)

Reflective cue	Way of knowing
<ul style="list-style-type: none"> • Bring the mind home • Focus on a description of an experience that seems significant in some way 	Aesthetics
<ul style="list-style-type: none"> • What particular issues seem significant enough to demand attention? 	Aesthetics
<ul style="list-style-type: none"> • How were others feeling and what made them feel that way? 	Aesthetics
<ul style="list-style-type: none"> • How was I feeling and what made me feel that way? 	Personal
<ul style="list-style-type: none"> • What was I trying to achieve, and did I respond effectively? 	Aesthetics
<ul style="list-style-type: none"> • What were the consequences of my actions on the patient, others and myself? 	Aesthetics
<ul style="list-style-type: none"> • What factors influenced the way I was feeling, thinking or responding? 	Personal
<ul style="list-style-type: none"> • What knowledge informed or might have informed me? 	Empirics
<ul style="list-style-type: none"> • To what extent did I act for the best and in tune with my values? 	Ethics
<ul style="list-style-type: none"> • How does this situation connect with previous experiences? 	Reflexivity
<ul style="list-style-type: none"> • How might I respond more effectively given this situation again? 	Reflexivity
<ul style="list-style-type: none"> • What would be the consequences of alternative actions for the patient, others and myself? 	Reflexivity
<ul style="list-style-type: none"> • How do I NOW feel about this experience? 	Reflexivity
<ul style="list-style-type: none"> • Am I more able to support myself and others as a consequence? 	Reflexivity
<ul style="list-style-type: none"> • Am I more able to realise desirable practice monitored using appropriate frameworks such as framing perspectives, Carper's fundamental ways of knowing, other maps? 	Reflexivity

refer to the way in which the cue tunes the practitioner into specific ways of knowing as delineated by Barbara Carper (1978):

- empirical – extant knowledge that provides the empirical basis for effective practice
- ethical – an appreciation of how best to respond in terms of societal benefit, expectations and norms
- personal – those things embodied within the practitioner that influence the way he or she sees and responds to the world
- aesthetic – the practical know-how and professional artistry used by each practitioner as they go about their work.

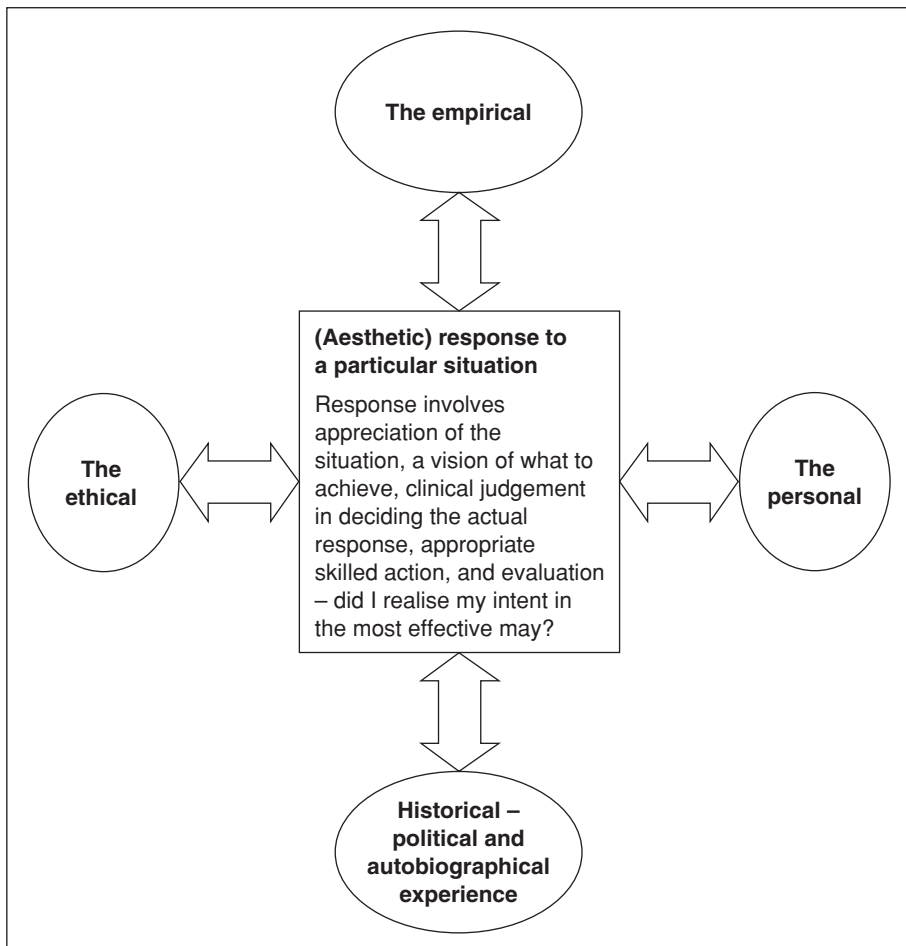
In accommodating these ways of knowing in the MSR, I identified a further domain which I termed 'reflexivity' (Johns 1995) to emphasise the impact of past experience on the present: the present turning back on itself to reflect on the way it has evolved from past experience. Such knowledge reflects the contextual – how knowing has been shaped by historical and contextual forces (see also White 1995; Freshwater & Rolfe 2001; Rolfe *et al.* 2001).

Carper's ways of knowing are a valid scheme for framing learning through reflection, although this scheme has tended to be too abstract for practitioners to interpret. Carper's scheme becomes practical when configured around aesthetic knowing (Box 1.2). So when practitioners describe a particular situation, they reveal their aesthetic knowing: the pattern for making sense of the situation, using clinical judgement and responding appropriately so as to realise a particular outcome, at least as they interpret it. The practitioner is then challenged to reflect on the way the empirical, personal, ethical and reflexive ways of knowing informed or might have informed their aesthetic response. A pattern of knowing emerges within the whole that can be appreciated and re-patterned towards realising more desirable practice in future similar experiences within a reflexive learning spiral for realising desirable practice.

I have explored models of reflection elsewhere (Johns 2004a) alongside other commentators (for example, Rolfe *et al.* 2001; Fitzgerald 2002). Sensible practitioners use these models creatively to help them see and learn through experience. A recent paper by Mary Woods (2003, p. 865), a lymphoedema clinic consultant who used the 1995 version of the MSR to reflect on her work with Kathryn, illustrates this. Mary writes:

Reflection is an active process (Conway 1996) that enables healthcare professionals to gain a deeper understanding of their experiences with patients. Johns (1995) suggests that action may then be taken towards increasing effectiveness in practice. Learning through reflection therefore enables the healthcare professional to respond to new situations from a changed perspective. It links past experiences to personal, moral, political and social concepts that have had an influence on the individuals involved in each encounter. Subsequent reflection on these influences acts as a vehicle for action and change.

Models or frameworks of reflection help healthcare professionals reflect on their practice effectively. They help to guide thoughts and focus attention on relevant

Box 1.2 Carper's fundamental ways of knowing (Carper 1978; Johns 1995, 2004a)

issues within the encounter. Johns' (1995) model for structured reflection adopts a humanistic approach, viewing the professional and patient as equal partners in creating the environment. The model uses simple questions that encourage a concern for the other person and is particularly fitting when reflecting on the interpersonal relationship between the professional and patient.

Mary chose the MSR because she felt it was in tune with her values and not merely an abstract technique. Jill Souter (2003) adapted the same version of the MSR to pay attention more explicitly to 'spiritual knowing' in palliative care. Although the use of the now outdated MSR is questionable, it does, however, seem to enable Jill to align herself with her practice values.

The risk with models of reflection is that they impose a (representation of) reality on the practitioner that forces a fit into the model rather than using the model as a creative opportunity: 'Our models are a prison. They are a way


to explore self. They act as filters that accept what we believe and reject what seems otherwise' (Levine 1986, p. 53). The practitioner needs to see models for what they are, a sense-making tool rather than a thought prison (Johns 2002, p. 45).

If reflection is a path towards transformation, then practitioners will need to walk the path well. Linear models of reflection may be helpful to guide the novice reflective practitioner to take their first steps along the reflective pathway. Yet, even as they stumble in their efforts to walk, reliance on their chosen models needs to be confronted with encouragement to give way to their intuitive instincts. Models are no more than an *aide mémoire*.

Towards a more balanced perception of reflection

In a recent paper (Johns 2004b) I set out a typology of reflection spanning from reflection-on-experience to mindful practice (Box 1.3). In this typology

Box 1.3 The span of reflective practice (Johns 2004a, b)

Layers of reflection	Key theorists	
<p><i>Reflection-on-experience</i> Reflecting on a situation or experience after the event with the intention of drawing insights that may inform my future practice in positive ways.</p>	<p>Mezirow (1981), Schön (1983, 1987), Boyd & Fales (1983), Boud <i>et al.</i> (1985), Johns (2004a)</p>	<p>Doing reflection</p>
<p><i>Reflection-in-action</i> Pausing within a particular situation or experience in order to make sense and reframe the situation so as to be able to proceed towards desired outcomes.</p>	<p>Schon (1983, 1987), Freshwater & Rolfe (2001)</p>	
<p><i>The internal supervisor</i> Dialoguing with self whilst in conversation with another in order to make sense.</p>	<p>Casement (1985), Rolfe <i>et al.</i> (2001)</p>	
<p><i>Reflection-within-the-moment</i> Being aware of the way I am thinking, feeling and responding within the unfolding moment and dialoguing with self to ensure I am interpreting and responding congruently to whatever is unfolding. It is having some space in your mind to change your ideas rather than being fixed on certain ideas.</p>	<p>Johns (2004a)</p>	
<p><i>Mindful practice</i> Being aware of self within the unfolding moment with the intention of realising desirable practice (however 'desirable' is known).</p>	<p>Freshwater (2002), Johns (2004a)</p>	<p>Reflection as a way of being</p>

reflection-on-experience is typified as a cognitive approach to reflection, that is, as something someone does. In contrast, mindful practice most typifies reflection as a way of being: a way that honours the intuitive and holistic nature of experience.

In my opinion, definitions of reflection as *reflection-on-experience* or *reflection-in-action* tend to reveal a (Western) cognitive approach that seeks to reduce experience into a rational understanding: a standing back from the situation to take an 'objective' view. Whilst this approach is useful it doesn't emphasise a view of reflection as a mindful, holistic and intuitive lens to view self within the unfolding moment. As Benner *et al.* (1996) assert, mindful practice is the essence of expert clinical judgement. It is the exquisite ability to appreciate the pattern of the unfolding situation from a position of deep ethical engagement within the situation.

Mindful practice

My quest for a more adequate representation of reflection led me to explore more diverse influences, most significantly Buddhist and Native American philosophy, that offered holistic and intuitive perspectives and balanced the cognitive approach. As with all things in life, balance is crucial for harmony. Whilst reason and rationality are important qualities, so too are perception, feelings and the senses if creativity is to flourish. This can be observed in, for example, the Taoist principles of yin and yang, the masculine and feminine, and negative and positive loops.

The Buddhist perspective would view reflection as a way to nurture and realise wise and compassionate practice within a strong ethic of doing good in the world. This understanding has strongly influenced my own work as a palliative care practitioner and complementary therapist towards easing suffering and nurturing growth by cultivating wise and compassionate care through reflective/mindful practice (Johns 2004c). Consider the following description of *bimadisiwin*:

Bimadisiwin is a conscious decision to become. It is time to think about what you want to be. The dance cannot be danced until you envision the dance, rehearse its movements and understand your part. It is demanding for every step needs an effort in becoming one with the vision. It takes discipline, hard work and time. Decide to be an active participant in your life journey. It is rewarding. Embrace the joy your vision brings you, it is yours to hold forever. It is freeing, for it frees the spirit. It releases you to become as you believe you must.

Believe in the vision of you

Practice the vision

Become the vision

(Jones & Jones 1996, p. 47)

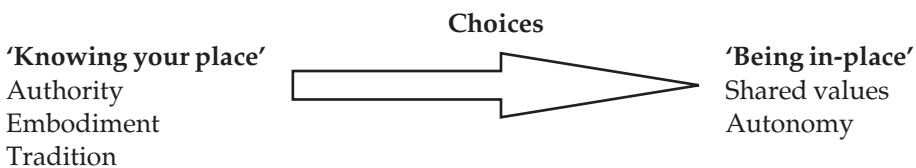
In my view, this absolutely captures the spirit of reflection – this notion of knowing and realising vision as a way of being. Ask yourself: 'What do I

aim to achieve at work?' 'What is caring?' 'Do I care?' 'Do I *really* care?' 'What constrains my caring?' Profound questions indeed.

Using descriptions of reflection like *bimadisiwin* opens the doors of perception as to what reflection is and helps confront my own constraints. I ask myself why I feel uncomfortable talking about Buddhism and Native American folklore with my students. Do I intuitively know they will label it flaky, hippy-dippy stuff and reject it? Are we so caught up in the technological world that such ideas are inherently threatening and must be resisted? If so, reflection will never realise its transformative potential. The MSR already incorporates Buddhist influence with the first cue 'bring the mind home' adopted from Sogyal Rinpoche's book *The Tibetan Book of Living and Dying* (Sogyal 1992).

Reflection is a path of self-awareness to become more self-conscious in terms of the actions we take towards realising our values or vision. Yet, as Young's theory of evolutionary consciousness (cited in Newman 1994) indicates, the decisions we make and actions we would take are constrained by our conditioning. As such we have to first unlearn or unwrap ourselves from these constraints, as difficult as that is because these constraints are deeply embodied and reinforced within the everyday world. It is as if we know our place within society and understand that to act out of place invites sanction from those more powerful keepers of tradition. Usually we self-regulate ourselves because we fear the consequences of acting out of place.

Milton Mayeroff (1971) writes about 'being in-place': the place a person needs to be in order to realise their values truly. So for myself, as a palliative care practitioner and complementary therapist, I need to be in-place to realise my vision of easing suffering and nurturing the growth of the other through their health-illness experience. Mayeroff contrasted 'being in-place' with 'knowing your place', a place determined by authority, embodiment and tradition rather than by values and a sense of autonomy, and which is often the wrong place to be if desirable practice is to be realised. Reflection then helps the practitioner to feel this tension between 'being in-place' and 'knowing your place' and the choices he or she needs to make in order to be in-place.



The reflective effort is to appreciate those forces that keep the practitioner in their place and constrain the necessary choices to move and be in-place; forces grounded in issues of tradition, authority and embodiment that limit the practitioner's ability to act autonomously on the grounds of rationality (Fay 1987). It is difficult to see beyond the normal self and the way one habitually thinks, feels and responds to the world. People are normative and take self for granted, often despite a deep gnawing of anxiety that indicates life is

not satisfactory. Coming to realise that self leads a contradictory life and that one is not as competent as one believed oneself to be may throw people into an existential crisis and may lower self-esteem, at least initially. Feeling impotent to change the way self is or to confront the constraints that impede the realisation of one's values may be very frustrating and anxiety provoking, especially if the person perceives self as powerless.

Hence, reflection always requires guidance to challenge and support the practitioner along the reflective journey; challenge to surface, confront and appreciate the contradictions between one's reality and the realising of one's vision; and support to give courage to make the right choices and take steps to shift the conditions that constrain and to move into the right place.

Reflection as humanities

"Reflection opens the door of perception to reveal experience. This can be presented as a story, either spoken or written. It might begin: Many new names greeted me on the whiteboard that informed the bed location of each patient. A small red candle burns on the desk to honour a patient who had died in the early hours of the morning. A nurse turns to her colleague and says, 'We need to clean the Rose Room now the undertakers have taken the body.' The Rose Room is where people in transit to the undertakers are discreetly placed. 'Rose' softens the impression of a mortuary. The use of the word 'body' confirms the person's transition from life to death. This is normal hospice talk yet I feel a tinge of regret as I would prefer to hear the nurses talk of Violet or Mrs Morrison.

I visit Martha. She is asleep. Outside the room, Millicent, Martha's daughter, chats with nurses. Eye contact, a smile, as I leave the room. Shortly afterwards I bump into Millicent in the small kitchen.

I say, 'You're Martha's daughter?'

'Yes, I'm Millie.'

I inform her I am the complementary therapist and had popped in to ask Martha if she would like any therapy. Millie exclaims tearfully that she is unable to touch her mum, that she is frightened of the consequences. She feels guilty. I instinctively touch her shoulder as if to reassure her that it was OK to hold such feelings whilst simultaneously reading the signs to check out if my touch response was appropriate. She visibly relaxes. I acknowledge how tough it is to dwell with people, even our mothers, as they die.

Martha is awake. I kneel by her side. She gazes at me with slightly hostile eyes as if I represent a threat. She has refused all treatment and wishes to die now. She has a urinary tract infection (UTI) but has refused antibiotics. I inform her I am a complementary therapist but she mishears: 'I don't want physiotherapy.' I gently reiterate that I am a complementary therapist. Less threatened, she asks what I do. In response she says she was a healer and practised Reiki. She asks me to see her later after she has spoken with her daughter. In the meantime she agrees to an aroma-stone – I use sandalwood

and lavender to combat the UTI odour, to help with the infection and to ease the anxiety in the room. Martha smiles as I leave her, as if we have a connection through our healing."

Reflection

Consider this text using the MSR cues (Box 1.1). In particular note the cue, 'To what extent did I act for the best and in tune with my values?' How would you determine the 'best' in this situation? Did I respect the daughter's and mother's autonomy? Did my actions benefit both daughter and mother? Did my touch violate the daughter's personal space and cause her some harm, especially as she has difficulty with touching her mother? Consider the cue 'What knowledge informed or might have informed me?' This is such a vast question in light of the extant knowledge available to me. Does such knowledge help me make sense of the daughter's response and despair and the mother's wish to die? Was my reassuring action in touching Millicent's shoulder appropriate in light of current research? Were sandalwood and lavender the best essential oils to help? Consider the cue 'What factors influenced the way I was feeling, thinking or responding'? Again a vast question to consider but at its core this question asks me how well I know myself and whether I am in the right place to realise desirable practice. These three specific cues illuminate the vast scope of reflection. Each of these cues can be addressed superficially, like scratching the surface of something very deep. Yet each cue, when listened to intently, takes me deeper and deeper into my experience as if carefully lifting back layer upon layer of veil to reveal the heart of self in the context of caring practice.

The experience with Millicent and Martha whilst apparently mundane on the surface is astonishingly profound. It is mundane in the sense that such experiences are commonplace within the hospice, and profound because of the intense feelings of the moment as someone draws close to death. Reflection always lifts experience out of the mundane into the profound: a sacred moment of dwelling with this woman and her daughter at such a moment in their lives. Reflection fosters a more sensitive and mindful approach to practice as I become more conscious and responsible for the decisions I make and the actions I take.

Instead of writing the story I could have painted the experience or written a poem. Art form seems to tap the right side of the brain where qualities of perception, imagination and creativity often lie dormant. Yet it is these very qualities that help to reveal the mystery of experience. As it was I didn't paint or write a poem in relation to my experience with Martha and Millicent, although my story telling has become increasingly poetic and less prosaic over time.

It is probably true to say that most of us lead habitual lives whereby much of experience drifts by with minimal attention as to the nature of the experience. Perhaps when the smooth flow of experience breaks down in some way,

we pay attention to try to fix the breakdown and move on. Reflection offers a way of paying attention, of opening the doors of perception. We may thus become mindful of each unfolding experience in such a way as to enable us to learn from that experience and move towards realising more desirable and satisfactory lives. In doing so, we can become more effective practitioners: wiser, more perceptive, more compassionate and more skilful.

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