

## Chapter 1

# Becoming Reflective

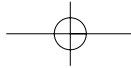
What does it mean to be a reflective practitioner? Is reflection something I write in a journal after work or perhaps it is something I do in clinical supervision? Is reflection a technology I might be exposed to on an educational course? Is it simply a form of thinking that I do anyway? Or is it a way of being within everyday practice that makes me more mindful of the ways I think, feel and respond to situations? Is it a particular style of leadership? Perhaps it is all of these things and more? In response to these questions, I am going to suggest a typology of reflective practices that moves from *doing* reflection towards reflection as a *way of being* within everyday practice (Box 1.1).

I suspect that many practitioners consider reflection as reflection-on-experience or reflection-on-action (Schön 1987): looking back at 'an experience' or some event that has taken place. The idea of an 'experience' is difficult to grasp: where does one experience begin and another end? Is experience not the endless flow of life? Is anticipating a forthcoming event an experience in itself? Simply put, an experience can be thinking, feeling or doing something.

Schön (1983, 1987) distinguished reflection-*on-action* with reflection-*in-action* as a way of thinking about a situation whilst engaged within it, in order to reframe and solve some breakdown in the smooth running of experience. Schön's thinking was influenced by Heidegger's idea of breakdown. Heidegger (1962, cited in Plager 1994) describes three inter-related modes of involvement or engagement with practical activity we have in day-to-day life:

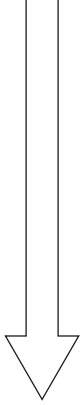
- *Ready-to-hand*: In the ready-to-hand mode of engagement, equipment and practical activity function smoothly and transparently. The person is involved in an absorbed manner so that the activity is for the most part unnoticed.
- *Unready-to-hand*: In the unready-to-hand mode, some sort of breakdown occurs in the smooth functioning of activity; becoming conspicuous to the user.
- *Present-to-hand*: In the present-to-hand mode, practical everyday activity ceases, and the person stands back and reflects on the situation.

The practitioner can adjust to minor interruptions to the smooth flow of experience without having to overtly think about it, because the body has embodied knowing. Sometimes the practitioner is faced with situations that do not go smoothly. In order to move on the practitioner must stand back



2 Chapter 1

**Box 1.1** Layers of reflection

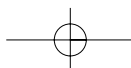
<p><i>Reflection-on-experience</i>: Reflecting on a situation or experience after the event with the intention of drawing insights that may inform my future practice in positive ways.</p> <p><i>Reflection-in-action</i>: Pausing within a particular situation or experience in order to make sense and reframe the situation proceeding towards desired outcomes.</p> <p><i>The internal supervisor</i>: Dialoguing with self whilst in conversation with another in order to make sense.</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 to certain ideas.</p> <p><i>Mindful practice</i>: Being aware of self within the unfolding moment with the intention of realising desirable practice (however desirable is defined).</p>	<p>Doing reflection</p>  <p>Reflection as a way of being</p>
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and consider how best to proceed. This is Schön's reflection-in-action, a type of problem-solving whereby the problem is considered, re-framed and ways of resolving the problem contemplated and tested to move on with the experience. It is easy to misunderstand reflection-in-action as *merely* thinking about something whilst doing it. Schön drew on examples from music and architecture, situations of engagement with inanimate forms. His example of counselling is taken from the classroom not from clinical practice. The classroom is a much easier place to freeze and reframe situations in contrast with clinical practice grounded within the human encounter.

Casement (1985), a psychoanalyst, offers a more satisfactory concept of reflection as the ability to dialogue with self whilst dialoguing with a client. He calls this dialogue with self the *internal supervisor* – paying attention to the way the self interprets what the other is saying and weighing up how best to respond. However, like reflection-in-action, it is a technique used in a particular situation.

The idea of paying attention to self within the unfolding moment defines *reflection-within-the-moment*; the exquisite paying attention to the way the self is thinking, feeling and responding within the particular moment, and those factors that are influencing the way self is thinking, feeling and responding. Such self-awareness moves reflection away from techniques to apply to a way of being.

*Reflection-within-the-moment* is developed through reflecting-on-experience: the more reflective I am after the event the more reflective I become within practice itself. Although I cannot prove this point in conventional research terms, most practitioners I have taught demonstrate this ability. As a



consequence normal everyday practice becomes alive and dynamic. The mundane becomes profound.

## Mindful practice

*Mindful practice* is, in essence, the same level of awareness as reflection-within-the-moment but distinguished by the conscious intent to realise a vision of practice. For example, as a complementary therapist and palliative care practitioner, my vision is *to ease suffering and nurture growth through the health-illness experience*. The idea of vision is further developed in Chapter 2. To realise this vision I must help the person appreciate their own suffering and envision a place where they might rather be – a place free from suffering, whether the suffering is physical, emotional, psychological, social or spiritual (Johns 2004).

Being mindful is fundamental to wisdom: the ability to make best judgements about situations by seeing the big picture for what it is. Within the complex and often indeterminate world of clinical practice, the ability to make good judgements would seem most significant, together with a deep compassion for the experience of the patient and family.

## Defining reflection

Definitions of reflection are characterised as learning through experience toward gaining new insights or changed perceptions of self and practice (Boud *et al.* 1985; Boyd and Fales 1983; Mezirow 1981). I describe reflection (adapted from the first edition) as 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.

From this description, the core characteristics of reflection can be elicited:

- practical wisdom
- reflexivity
- becoming mindful
- commitment
- contradiction
- understanding
- empowerment

## Practical wisdom

The reflective effort is towards enabling practitioners to develop practical wisdom: the practitioner's knowing within the particular situation. Much has been written and debated about the distinction between art and science in nursing knowledge. Science is seen as the hard evidence whilst artistry is viewed as what nurses actually do. The work of Carper (1978) helps to visualise the wholeness of practical wisdom and the way types of knowledge integrate to inform practical wisdom woven together in unique patterns of knowing in response to each particular situation.

### *Carper's fundamental ways of knowing in nursing*

At the core of Carper's work is the *aesthetic* way of knowing (Johns 1995) or what I now describe as practical wisdom. Practical wisdom is reflected in the way the practitioner grasps, interprets, envisages what is to be achieved and responds to the unfolding moment. In essence this is practical wisdom: clinical judgement and response.

As I set out in Box 1.2, practical wisdom or aesthetics is influenced by *the empirical, the ethical, the personal patterns of knowing* and what I term *reflexivity*, that together weave the unique pattern of knowing reflected in the practitioner's practical wisdom of each particular experience. Carper describes the empirical as:

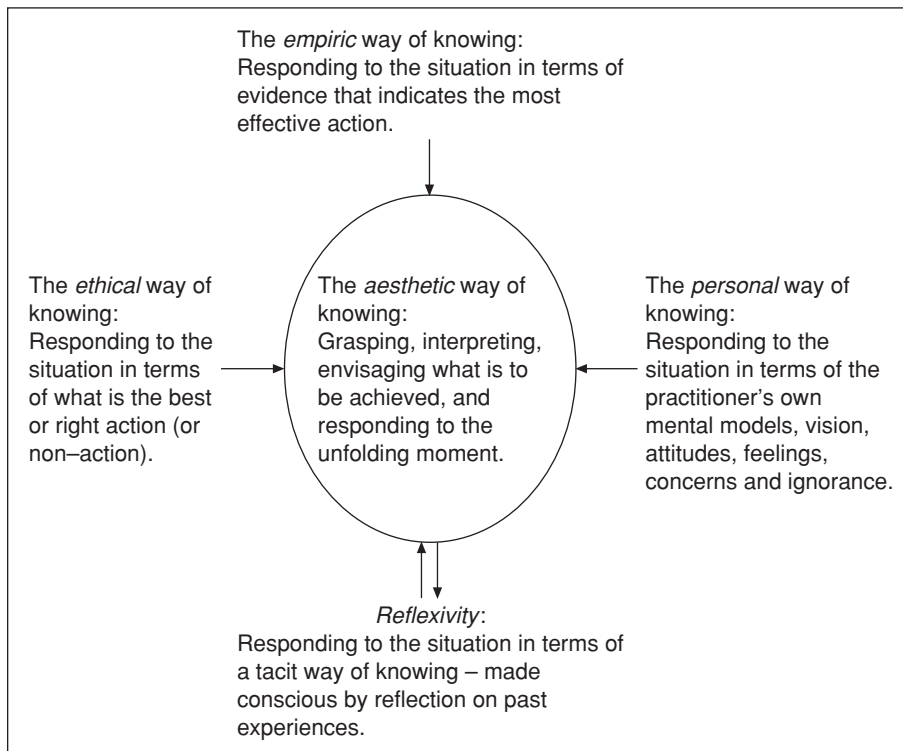
'Knowing knowledge that is systematically organised into general laws and theories for the purpose of describing, explaining and predicting phenomena of special concern to the discipline of nursing'. (p. 14)

I would extend this empirical view of knowledge to include all sources of extant knowledge that might inform the practitioner within the particular clinical moment. Practitioners draw on different types of knowledge, both subjective and objective, each with its own rules for determining its truth claims (Johns 2002; Wilber 1998). *Reflexivity* acknowledges both the influence of previous experience on clinical judgement and response, and the impact of applying new insights about practice through reflection on future experience.

### *Reflexivity*

My description of reflection states that *the practitioner can gain new insights into self and be empowered to respond more congruently in future situations within a reflexive spiral towards realising one's vision as a lived reality*. Such words reflect the purposefulness of reflection: it is action oriented towards the development of practical wisdom and realisation of vision. Reflexivity is a looking back and reviewing self's development over time: the way insights have emerged and influenced future experience. In this sense, reflection is like a drama unfolding over time, a systematic and disciplined pursuit towards realising desirable practice however that is known. As I shall explore, the practitioner can utilise markers to plot the reflexive journey of development.

**Box 1.2** Carper's fundamental pattern of knowing in nursing (1978) (reproduced from Johns 1995a)



**Becoming mindful**

The idea of a *window* is to look inside at self, to understand the way I am thinking (head), feeling (heart) and responding (hand) to situations as I do, and also use a window to look out at practice, in particular the way the environment influences the way I am thinking, feeling and responding. I shall assume that the effective practitioner seeks congruence between head, heart and hand (Cope 2001).

There is a beautiful complexity of growth through reflection. Extending *window* as a metaphor, O'Donohue (1997) notes the way:

'many people remain trapped at the one window, looking out every day at the same scene in the same way. Real growth is experienced when you draw back from that one window, turn and walk around the inner tower of the soul and see all the different windows that await your gaze. Through these different windows, you can see new vistas of possibility, presence and creativity. Complacency, habit and blindness often prevent you from feeling your life. So much depends on the frame of vision – the window through which we look.' (pp. 163–64)

The image of practitioners opening shutters to see themselves and practice is a powerful visualisation of mindfulness – the antidote to complacency, habit and blindness that O'Donohue poetically captures.

### ***Commitment***

In my definition of reflection I suggested that commitment was necessary for reflection. Fay (1987) considers that commitment, or what he terms wilfulness, besides the qualities of openness, curiosity and intelligence, are prerequisites for reflection – I pay attention to something because it matters to me. Why else would I pay attention to it except to relieve my anxiety? I pay attention to my ‘experience’ because I constantly strive to become a more effective practitioner and realise my vision of practice.

This commitment is the very heart of what it means to be caring. Because I pay attention to my practice I am open to what is unfolding. Being open I am not defensive, but curious and ready to consider new possibilities. Every situation becomes an opportunity for learning. Curiosity is being mindful – Why do I feel that way? Why do I think that way? Why do I respond that way? Why are the walls green? Does music help patients relax? Why is Jim unhappy – would a SSRI anti-depressant work better than a tricyclic? Etcetera. Everything enters into the gaze of the curious practitioner on her quest to realise desirable and effective practice. From this angle it is perhaps easy to see the scope of reflection. As Gadamer (1975) noted:

‘The opening up and keeping open of possibilities is only possible because we find ourselves deeply interested in that which makes the question possible in the first place. To truly question something is to interrogate something from the heart of our existence, from the centre of our being.’ (p. 266)

If things are not cared for they wither and die. When those things are people then the significance of commitment becomes only too apparent. Commitment harmonises or balances conflict of contradiction, it is the energy that helps us to face up to unacceptable situations. As Carl Rogers (1969) notes, the small child is ambivalent about learning to walk; he stumbles and falls, he hurts himself. It is a painful process. Yet the satisfaction of developing his potential far outweighs the bumps and bruises. As I know only too well through years of guiding practitioners to learn through experiences, nurses reflect on painful situations. Practice is not always a pretty sight. Yet with commitment, even in the darkest moments, the glimmer of caring shines through. The realisation of caring within such moments is profoundly satisfying and sustaining, it nourishes commitment and reaffirms our beliefs. No words express this sentiment better than Van Manen (1990):

‘Retrieving or recalling the essence of caring is not a simple matter of simple etymological analysis or explication of the usage of the word. Rather, it is the construction of a way of life to live the language of our lives more deeply, to become more truly who we are when we refer to ourselves [as nurses].’ (p. 58)

Perhaps many practitioners have had their commitment numbed or blunted through lack of attention or working in uncaring environments. It is a tough world out there where it can be very difficult to realise one’s caring ideals in the pressure to get through the work with limited resources. Perhaps satisfaction is making it through to the end of the shift with minimal hassle rather than

fulfilling caring ideals. Often when things get overly familiar we no longer pay attention to them. As O'Donohue (1997) notes:

'People have difficulty awakening to their inner world, especially when their lives become familiar to them. They find it hard to discover something new, interesting or adventurous in their numbed lives.' (pp. 122–3)

Practitioners who have become numb will not enjoy reflection. Indeed they will turn their heads away from the reflective mirror because it is too painful or do not want to face themselves and the responsibility to care. On the other hand, reflection offers the practitioner a way to re-ignite commitment and reconnect to caring ideals.

### ***Contradiction***

Contradiction is the *creative tension* that exists between our visions of practice and our current reality (Senge 1990). This tension is the learning opportunity. For people concerned with doing what is best, this tension can feel uncomfortable or like a gnawing ache. Reflection is often triggered by negative feelings such as anger, guilt, sadness, frustration, resentment or even hatred. Such feelings create anxiety within the person and bring the situation that caused these feelings into the conscious mind. The practitioner may *naturally* reflect either consciously or subconsciously to try and defend against this anxiety in order to try and bring self back into a harmonious state. The practitioner may distort, rationalise, project or even deny the situation that caused the feelings. They may take action to relieve the tenseness anxiety causes by attacking the source of the negative feeling or taking it out on someone else. They may more quietly talk it through with someone willing to listen, or, more vigorously, take some exercise. We all have our own tactics for such moments. We may even write in a journal.

On the other hand, the practitioner may reflect on positive feelings such as satisfaction, joy and love. However this is less likely because we are more likely to accept such feelings. Experiences that arouse no strong feelings are simply taken for granted, that is until the practitioner becomes *mindful*, in which case all experience becomes available for reflection.

Reflection is cathartic in encouraging the expression and understanding of strong feelings. In this process, negative feelings or energy can be converted into positive energy for taking future action based on an understanding of the situation and appropriate ways of responding. Lydia Hall (1964) puts this succinctly:

'Anxiety over an extended period is stressful to all the organ functions. It prepares people to fight or flight. In our culture however, it is brutal to fight and cowardly to flee, so we stew in our own juices and cook up malfunction. This energy can be put to use in exploration of feeling through participation in the struggle to face and solve problems underlying the state of anxiety.' (p. 151)

Reflection offers a path for the exploration of feeling. Yet to do this may require guidance because of learnt responses to anxiety. The nature of guidance

8 *Chapter 1*

and clinical supervision as a particular form of guidance is developed in Chapter 3.

The idea of contradiction resonates with critical social science concerned as it is with the liberation of individuals and groups from states of oppression to realise practitioners' own best interests. Whether you view nurses or nursing as oppressed makes for interesting debate. Fay (1987) views reflection as a critical process moving three stages of enlightenment, empowerment and emancipation towards overcoming the forces that constrain practitioners from realising desirable practice. Each stage represents a significant level of learning:

Enlightenment (understanding)	Understanding why things have come to be as they are in terms of frustrating self's realisation of desirable practice.
Empowerment	Creating the necessary conditions within self whereby action to realise desirable practice can be undertaken.
Emancipation (transformation)	A stable shift in practice congruent with the realisation of desirable practice.

***Understanding***

Understanding is the basis for making good judgement and taking action congruent with realising desirable practice. It is only when practitioners understand themselves and the conditions of their practice that they can begin to realistically plan how they might respond differently. Yet we do not live in a rational world. There are barriers that limit the practitioner's ability to respond differently to practice situations even when they know there is a better way of responding to situations in tune with desirable practice. These barriers blind and bind people to see and respond to the world as they do.

People are not radically free to act on rationality but are bound by social norms (tradition), by power relationships with others (authority) and by previous learning that has become embodied (embodiment). By embodiment I mean I do not have to think about how to do something because my body has learnt to do it, for example driving a car. Of course, this makes learning to do something differently difficult because what is embodied has to be unlearnt. Because of the forces of tradition and authority, practitioners' freedom to act is a relative freedom in terms of the limits imposed by normal society. Change is always a process of social change because of the way change disrupts the status quo. As such, there is always a built-in resistance to change in order to maintain the status quo even by those who may benefit from change. In exploring the nature of contradiction, the practitioner must inevitably explore the conditions that bind her to normal ways of being. The effort is to un-bind in order to move on.

***Empowerment***

Returning to my definition of reflection, I suggested that it is the force of conflict, commitment and understanding that empowers the practitioner



to take action based on insights. Kieffer (1984) noted that the process of empowerment involved:

'Reconstructing and re-orientating deeply engrained personal systems of social relations. Moreover they confront these tasks in an environment which historically has enforced their political oppression and which continues its active and implicit attempts at subversion and constructive change.' (p. 27)

Kieffer's words are very powerful and may not rest comfortably with many readers. Yet the truth of the situation is stark; if practitioners truly wish to realise their caring ideals then they have no choice but to become political in working towards establishing the conditions of practice where that is possible.

Yet, the health care agenda has shifted considerably in recent years, opening up the possibilities for practitioners to expand their roles. On the other hand, it might be argued that the health care agenda has become increasingly concerned with productivity rather than care processes. In response practitioners may feel frustrated, leading to low morale, increased dissatisfaction and burnout. Practitioners may respond by shifting things on the surface but real change is much deeper.

### *Developing voice*

The emergence of *voice* is a powerful metaphor for empowerment, as exemplified through the work of Belenky *et al.* (1986). Belenky and her co-researchers, in examining women's ways of knowing, describe five different perspectives from which women view reality and draw conclusions about truth, knowledge and authority: silence, received knowing, subjective knowing, procedural knowing, and constructed knowing. These different voices offer a pathway to plot increasing levels of empowerment. I use the pathway to guide practitioners to appreciate and develop what voices they are using within specific situations. The pathway also works for men although the tendency of men towards a morality based on justice rather than a morality based on responsibility and care may result in a different pattern of men's knowing; an assumption drawn from Gilligan's work (1993) *In a Different Voice*.

### *Silence*

At the level of silence practitioners have no voice. They are not lost for words so much as have no words to say. It is the position of the subordinate and powerless practitioner. Perhaps you can remember being silenced, not so much by others but by yourself. Practitioners often say 'I wish I had said something but . . .'.

Is it fear of repercussion or humiliation? Either way, it is a reflection of knowing your place to be silent in a situation. Think of a recent experience when you would have liked to say something. Write it down and ask yourself why you were silent. What would you liked to have said? How did you feel? What do you imagine the response of others to be?

## 10 Chapter 1

Cumberlege observed at meetings concerned with the discussion of her report on community nursing that doctors sat in the front rows and asked all the questions, whilst nurses sat in the back rows and kept silent. She commented how nurses needed to find a voice so they could be heard, otherwise they would have no future in planning health care services.

### *Received knowing; the voice of others*

At the level of received knowing, practitioners listen and speak with the voices of others that they have embodied. They conceive themselves as capable of receiving, even reproducing, knowledge from the all-knowing external authorities but not capable of creating knowledge of their own.

When I read these words I am reminded of my 'nurse training' and how I was filled with this type of knowledge usually copied verbatim from the all-knowing external authorities. I have no sense of being enabled to develop critical thinking skills, and even if I had, the all-knowing authorities within clinical practice would have soon put me in my place. Despite the rhetoric of developing the practitioner as a critical thinker, the weight of tradition and authority continues to suppress her emergence.

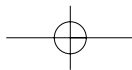
So when I ask a nurse, 'Why do you do it like that?' she is likely to reproduce knowledge from an external authority that has been unquestioned. When I ask her how else she might do it, she may struggle to think laterally, locked into habitual patterns of response. The reflective perspective at this level is to simply challenge the taken for granted and veracity of received knowledge.

### *Subjective: the inner voice*

At the level of subjective knowing, the practitioner is engaged on a quest for self: listening to, valuing and accepting her own voice as a source of knowing. This may mean rejecting the authoritative voice that has dominated the way the practitioner views, thinks about and responds to the world. It is like waking up and seeing yourself as a person in your own right. The subjective voice may be confusing, because it is competing with received voices, hence it is easy to discount one's own subjective voice as being unsubstantiated, even ridiculed by more 'knowing' others. Listening to self, the self may see an uncanny stranger on display, a self that has been censored (Cixous 1996).

This is the voice that reflective practice seeks to surface in the first place. Yet it can also be a tentative voice, vulnerable in its uncertainty, and hence may need to be nurtured in a community of like-minded people. Belenky *et al.* (1986) note:

'During the period of subjective knowing, women lay down procedures for systematically learning and analysing experience. But what seems distinctive in these women is that their strategies for knowing grow out of their very embeddedness in human relationships and the alertness of everyday life. Subjectivist women value what they see and hear around them and begin to feel a need to understand the people with whom they live and who impinge on their lives. Though they may be emotionally isolated from others at this point in their histories, they begin to actively analyse their past and current interactions with others.' (p. 85)



Reflection encourages the practitioner to pay attention to self within the context of human relationships and encourages this alertness to everyday life. The idea that practitioners are isolated is intriguing, many nurses talk of chatting with others, but to what purpose? Does such chat reinforce prejudices and discontent or does it enable the growth of knowing?

*Procedural knowing: the connected and separate voices*

I suggested that the subjective voice was largely unsubstantiated and, as such, at risk of being dismissed. At the level of procedural voice, the voice becomes increasingly substantiated because it is grounded in techniques of knowing the world.

**The connected voice**

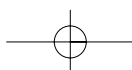
Connected knowing is the ability to connect with the experiences of others through empathy. What is the other experiencing? What meanings do others give to their experience? Empathy is a dispassionate view, because in order to sense what it is like for the other, the practitioner must first know and clean her viewing lens to see the other's experience in the other's own terms rather than her own distorted interpretation. I shall pick this point up in Chapter 4 when considering the significance of knowing the person, but we can see that at this level, knowing the other is not simply opinion but grounded in connection. When the practitioner is skilled and confident at this level her voice becomes powerful in challenging the perceptions of others and ensuring that the other's voice is indeed heard within decision-making loops. The connected voice is the feminine voice grounded in morality of responsibility and care.

**The separate voice**

In contrast with the connected voice, the separate voice is dispassionate in its ability to critique and reason. It is the rational voice that seeks to understand things in terms of logic and procedures. It is the antithesis of received knowledge: no longer is knowledge accepted on face value but now challenged for its validity and appropriateness to inform the particular situation. This voice is the dominant voice within organisations, thirsting for the 'facts' and reasoned argument, even though most decisions are made in terms of authority and subjectivity. The separate voice is the masculine voice grounded in rules for justice.

*Constructed knowing*

At the level of constructed knowing, the practitioner weaves the subjective and procedural voices into an informed, connected to self and others, passionate and assertive voice. There is no longer any dualistic thinking between art and science as they are woven into practical wisdom. From the perspective of constructed voice practitioners view all knowledge as contextual, experience themselves as creators of knowledge and value both subjective and objective strategies for knowing. Virginia Woolf (1945) considered that the great mind



## 12 Chapter 1

was androgynous, having found the balance between masculine and feminine. Knowing is deeply embodied and expressed in intuitive ways. However, to close the circle, even practitioners capable of speaking with this level of voice may be silenced:

‘Even among women who feel they have found voice, problems with voice abound. Some women told us, in anger and frustration, how frequently they felt unheard and unheeded – both at home and work. In our society which values male authority, constructivist women are no more immune to the experience of feeling silenced than any other group of women.’ (Belenky *et al.* 1986, p. 146)

### Writing as agentic action

Picking up the sentiment expressed in Belenky *et al.*'s quote, another way to view empowerment is in terms of realising and sustaining agency. Agentic people are clear on what they want to accomplish, understand how intended actions will contribute to their accomplishments and are confident that they can complete the intended actions and attain their goals. In contrast, the practitioner may perceive herself as a victim, feeling powerless to take action to realise her vision of practice.

The reflective effort is to move from the victimic position to become agentic (Polkingthorne 1996). To view self as a victim is to experience a loss of person-hood and to project the blame for this loss onto others rather than take responsibility for self. Loss theory (Marris 1986) highlights the need for people to connect between the past (traumatic) event and the present. Indeed it is this search for meaning that characterises this phase of life. Marris (1986) suggests that until people have made this connection it is difficult for them to move positively into an optimistic future.

In the victimic role the person is passive and receptive. Victimic people depict their lives as being shaped by events beyond their control. Others' actions and chance determine life outcomes, and the accomplishment or failure to achieve life goals depends on factors they are unable to change. Bruner (1994) notes that persons construct a victimic self by:

‘reference to memories of how they responded to the agency of somebody else who had the power to impose his or her will upon them, directly or indirectly by controlling the circumstances in which they are compelled to live.’ (p. 41)

Bruner's words highlight that the construction of life plots is always in relation to others. They are oriented towards avoiding negative possibilities rather than to actualising positive possibilities. In contrast, Cochran & Laub (1994) (as cited in Polkingthorne 1996), considered that the change from a victimic to agentic identity consisted of two correlative movements: the progressive construction of a new agentic life story, and the destruction and detachment from the victimic life story. The victimic plot does not simply fade away; it must be actively confronted, which can generally be seen moving within four phases:

- Phase 1: This first phase is dominated by the person's sense of entrapment or incompleteness, being controlled, helplessness – described as 'trapped in a world in which most of what makes life worthwhile is gone, and threatened by the possibility that this bleak existence might extend indefinitely.' (p. 90)
- Phase 2: In phase 2, people become involved in activities that will assist in (re)gaining an agentic life. Escape from phase 1 begins with the formation of a goal that is worthwhile and attainable (vision). The person takes ownership of their practice, and can see that their efforts make a difference and affect outcomes. The person monitors her progress and establishes standards for success in achieving progressively more difficult goals. Experiences of success in achieving their goals are crucial to validate the person's capacity to make a difference and fuel their optimism for a better future and produce a sense of freedom and control.
- Phase 3: In phase 3, people engage in activities more closely related to their goals in more self-directed ways – what Cochran & Laub (1994) describe as actually playing the game, whereas phase 2 was practising the game. The person becomes aware that the remaining major barriers to fuller and more agentic life reside as much in their own beliefs and attitudes; rather than outside themselves.
- Phase 4: In phase 4, people experience a liberating sense of completing their goals. Cochran & Laub (1994) note: 'Now one lives with a sense of life being on course, full, open to possibilities unrestricted' (p. 94). The person has achieved a sense of wholeness that is no longer threatened by former recollections. They have become authors of their own lives and taken control of their existence.

Reflection and writing would enhance the core ingredients of personal agency: self-determination; self-legislation; meaningfulness; purposefulness; confidence; active-striving; planfulness; and responsibility (Cochran & Laub, cited in Polkingthorne 1996). The person's work is to create a plot out of a succession of actions as if to direct the actor in the midst of action. Locating ourselves within an intelligible story is essential to our sense that life is meaningful (p. 812). Being an actor at all means trying to make certain things happen, to bring about desirable endings, to search for possibilities that lead in hopeful directions. As actors, we require our actions to be not only intelligible but to get us somewhere. We act because we intend to get something done, to begin something which we hope will lead us along a desirable route. And we act with what Kermode (1966, cited in Mattingly 1994) calls the 'sense of an ending':

'Because we act with the sense of an ending, we try to direct our actions and the actions of other relevant actors in ways that will bring the ending about.' (p. 813)

## The significance of reflective practices for professional practice

Schön (1987) in his book *Educating the Reflective Practitioner* opens with these words:

'In the varied topography of professional practice, there is the high, hard ground overlooking the swamp. On the high ground, manageable problems lend themselves to solution through the application of research-based theory and technique. In the swampy lowland, messy, confusing problems defy technical solution. The irony of this situation is that the problems of the high ground tend to be relatively unimportant to individuals or society at large, however great their technical interest may be, while in the swamp lie the problems of greatest human concern. The practitioner must choose. Shall he remain on the high ground where he can solve relatively unimportant problems according to prevailing standards or rigor, or shall he descend into the swamp of important problems and non-rigorous inquiry?' (p. 1)

Schön's *swampy lowlands* draws attention to the type of knowing that practitioners need in order to respond to the problems of everyday practice that defy technical solution. Perhaps this is no more true than in nursing, where the nurse faces issues of distress and conflict within the unique human-human encounter on a daily basis. Having no solutions to apply, the practitioner must draw on her intuition, tuned through previous experience, to inform her response. Schön's distinction between the swampy lowland and the hard high ground reflects the dualism between art and science. The dualism is unhelpful and needs to be firmly pushed aside and replaced with the idea of practical wisdom.

Schön (1983, 1987) describes empirics as 'technical rationality' and notes that this type of knowledge has traditionally been the most valued type of professional knowledge above the type of knowing necessary to effectively navigate the swampy lowlands. Schön challenges this value hierarchy, suggesting that swampy lowland knowledge is most significant because it is the knowledge practitioners need to practice. Such knowledge is subjective and contextual. Subjective knowing has often been denigrated as a lesser form of knowing, even dismissed as 'anecdotal' by those who inhabit the hard high ground of technical rationality. It is as if people get locked into a paradigmatic view of knowledge and become intolerant of other claims because such claims fail the technical rationality rules for what counts as truth.

Benner (1984) and Benner *et al.* (1996), in determining the pathway from *novice to expert*, drew heavily on Dreyfus & Dreyfus's model of skill acquisition (1986), to consider the nature of expertise (see Box 1.3 for a comparison of novice and expert characteristics). In contrast with novices, experts intuit and respond appropriately to a situation as a whole without any obvious linear or reductionist thinking. These experts intuit by drawing on a reservoir of embodied or tacit knowing especially in situations of existential caring and coping skills akin to Schön's swampy lowlands. The novice simply does not have this tacit knowledge accumulated from past experiences. Reflection as a learning process,

**Box 1.3** Comparison of novice–expert characteristics

<b>NOVICE</b>	←—————→	<b>EXPERT</b>
Linear thinking and acting		Intuitive
View parts in isolation from whole		Holistic or gestalt vision
Reliance on external authorities		Reliance on internal authority
See self as separate from situation		See self as integral to the situation
Application of knowledge		Wisdom

enables the practitioner to surface, scrutinise, and develop her intuitive processes and, *ipso facto*, to develop her tacit knowing. As Holly (1989) notes:

‘It [keeping a reflective journal] makes possible new ways of theorizing, reflecting on and coming to know one’s self. Capturing certain words while the action is fresh, the author is often provoked to question why . . . writing taps tacit knowledge; it brings into awareness that which we sense but could not explain.’ (pp. 71, 75)

As a consequence, the practitioner may, on subsequent experiences, respond differently although still on an intuitive level. This is subliminal learning, only revealed in light of reflection on subsequent experiences. Of course, learning through reflection also takes place on a deliberative level. Indeed, through reflection, the practitioner will become more mindful and increasingly sensitive to her intuitive responses.

Cioffi (1997) draws on the work of Tversky & Kahneman (1974) to suggest that judgements made in uncertain conditions are most commonly heuristic in nature. Such processes are servants to intuition. The heuristics intend to improve the probability of getting intuition right by linking the current situation to past experience, being able to see the salient points within any situation, and having a baseline position to judge against. Without doubt, the majority of decisions practitioners make are intuitive. King & Appleton (1997) and Cioffi (1997) endorse the significance of intuition within decision making and action following their reviews of the literature and rhetoric on intuition; they note that reflection accesses, values and develops intuitive processes. The measured intuitive response is wisdom, another key quality of expertise.

Studies have been undertaken in an attempt to understand why research is not used in practice by practitioners (Armitage 1990; Hunt 1981). These authors suggest that blame lies with the practitioners because of their failure to access and apply research. However, Schön (1987) argues that little research has been done to address the real problems of everyday practice and that research always needs to be interpreted by the practitioner for its significance to inform the specific situation. The decontextualised nature of most research with its claims for generalisability makes this a difficult, if not impossible, task. Any claim for generalisability *must* be treated with extreme caution within unique human–human encounters. Such encounter is essentially unpredictable. The insensitive application of technical rationality is likely to lead to stereotyping: fitting the patient to the theory rather than using the theory to inform the situation. Schön exposes the illusion that research can simply be applied.

## 16 Chapter 1

Technical rationality (or evidence-based practice) has been claimed as necessary for nursing's disciplinary knowledge base because it can be observed and verified (Kikuchi 1992). Historically, professions such as nursing have accepted the superiority of technical rationality over tacit or intuitive knowing (Schön 1983, 1987). Visinstainer (1986) notes that:

'Even when nurses govern their own practice, they succumb to the belief that the "soft stuff", such as feelings and beliefs and support, are not quite as substantive as the hard data from laboratory reports and sophisticated monitoring.' (p. 37)

The consequence of this position in nursing has been the repression of other forms of knowing that has perpetuated the oppression of nurses and of their clinical nursing knowledge (Street 1992). Since the Briggs Report (DHSS 1972) emphasised that nursing should be a research-based profession, nursing has endeavoured to respond to this challenge. However, the general understanding of what 'research-based' means has followed an empirical pathway reflecting a dominant agenda to explain and predict phenomena. This agenda has been pursued by nurse academics seeking academic recognition that nursing is a valid science within university settings. Whilst such knowledge has an important role in informing practice it certainly cannot predict and control, at least not without reducing the patient and nurses to the status of objects to be manipulated like pawns in a chess game.

Schön's notion of the hard high ground and the swampy lowlands reflect two types of knowing. However, I will take issue that the practitioner must choose which land to inhabit. Because of the very nature of everyday practice the practitioner must dwell in the swampy lowlands, and yet be comfortable with visiting the high hard ground for information to inform and assimilate into practice. Perhaps the reader can sense the swampy lowland as the world of the connected voice, and the high hard ground as the world of the separate voice. The reflective effort is to integrate these different ways of knowing in becoming a constructed voice.

### Accessing reflection

People often say to me, 'Isn't it natural to reflect?', 'Don't we all do it anyway?', 'So what's the fuss?'. People think that reflection is just thinking about something and don't we all think? Well perhaps we do but that does not mean we reflect with the intention of learning through our thinking to develop new insights or perceptions of self and to shift the way we view and feel about the world.

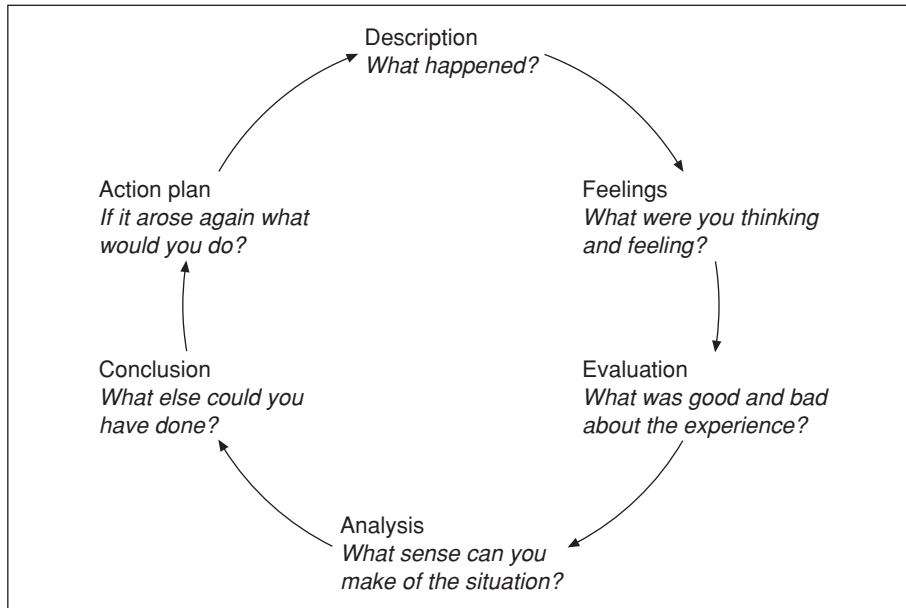
Someone approaching reflection for the first time might ask certain questions:

- What is reflection?
- How do I do it?
- How do I know if I am doing it properly?
- How do I learn through reflection?



Numerous frameworks for facilitating reflection have been developed. In particular I introduce practitioners to four models that the practitioner can consider for their usefulness. These are Gibbs's reflective cycle (1988) (Box 1.4), Boyd and Fales's stages of reflection (1983) (Box 1.5), Mezirow's levels of consciousness (1981) (Box 1.6), and my own model for structured reflection

**Box 1.4** Gibbs's reflective cycle (1988)



**Box 1.5** Boyd and Fales's stages of reflection (1983)

- a sense of inner discomfort
- identification or clarification of concern
- openness to new information from external and internal sources
- resolution
- establishing continuity of self with past, present and future
- deciding whether to act on the outcome of the reflective process

**Box 1.6** Mezirow's levels of reflectivity

**Consciousness level**  
 Affective reflectivity: becoming aware of how we feel about things.  
 Discriminant reflectivity: perceiving the relationships between things.  
 Judgmental reflectivity: becoming aware of how we make value judgements.

**Critical consciousness level**  
 Conceptual reflectivity: questioning the adequacy and morality of concepts.  
 Psychic reflectivity: recognising one's own prejudices and the impact of these on judgement and action.  
 Theoretical reflectivity: understanding self in the context of desirable action.

**Box 1.7** Model for structured reflection – 14th edition

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

(Box 1.7). This list is not exclusive; other models exist, which may have value for the practitioner.

Gibbs's reflective cycle takes the reflective practitioner through six stages. At each stage the practitioner considers a cue to help them reflect on experience. From the very outset, practitioners need to be encouraged to write vivid and spontaneous descriptions of their experiences. The emphasis on feelings is very significant because most reflection is triggered by feelings and decision is influenced by feelings (Callahan 1988). Gibbs's stages of *What was good or bad about the experience* and *Making sense* confront the practitioner to consider their normal way of thinking and responding within the situation toward gaining insights into self and practice. Boyd and Fales describe this perspective shift as *Changed perceptions* whilst Mezirow describes it as *Perspective transformation*. Gibbs's stages of *What else could you have done?* and *If it arose again what would you do?* focuses the practitioner on anticipating, fantasising and rehearsing other ways of responding with a view on future practice.

Boyd and Fales's (1983) six stages for reflection share much in common with Gibbs's model, which is reassuring for the would-be reflective practitioner wondering which model to use. Boyd and Fales's last stage *Deciding whether to act on the outcome of the reflective process* suggests that acting on perceptions and insights gained through reflection is deliberative. Perhaps on one level it is, but on another, altogether deeper intuitive level, changed perceptions of self must inevitably lead to changed actions.

Mezirow viewed reflection as emancipatory action, strongly influenced by the critical social science perspective. Mezirow's work suggests the depth of reflection through a number of processes spanning from consciousness: the way we might think about something, to critical consciousness: where we pay attention and scrutinise our thinking processes. This is a very significant idea, because it acknowledges that the way we think or feel about something may, itself, be problematic. I explore this idea more deeply in considering the nature of dialogue in Chapter 3.

### *Guarding against a prescriptive legacy*

I am wary of cyclical or stage models because they suggest that reflection is an orderly step-by-step progression. There may be some value for stage models for novice practitioners in helping them grasp the essence of reflection, although I think the model for structured reflection does this adequately without the need for stages. My caution is that stage models immediately present reflection as some technical linear task. In a technology-driven society the risk exists that reflective models will be grasped as a technology and used in concrete ways. From a technological perspective, as opposed to a reflective perspective, the risk is that practitioners will fit their experience to the model of reflection rather than use the model creatively to guide them to see self within the context of the particular experience (I make the same point about models of nursing in Chapter 2). I have even seen the Model for Structured Reflection converted, or rather distorted, into a cyclical form (for example, see Bond & Holland 1998).

I must emphasise that all models of reflection are merely devices to help the practitioner access reflection, they are not a prescription of what reflection is. In other words, models are heuristic, a means toward an end, not an end in itself. From a reflective perspective, the practitioner will view all models for their value, rather than accepting the authority of the model on face value. Rather like the skilled craftsman, the practitioner will choose the tool that is most helpful.

Reflect on Rinpoche's words (1992):

'Largely because of our Western technological culture people tend to be absorbed by what I would call "the technology of meditation" [reflection]. The modern world, after all, is fascinated by mechanisms and machines, and addicted to purely practical formulae. But by far the most important feature of meditation [reflection] is not the technique, but the spirit: the skilful, inspired, and creative way in which we practice [reflect], which could also be called the "posture".' (pp. 64–5)

### **The model for structured reflection – MSR**

The model for structured reflection is a technique to guide practitioners to access the depth and breadth of reflection necessary for learning through experience. The MSR was first designed in 1991 through analysing the pattern

## 20 Chapter 1

of dialogue that took place in guided reflection relationships and then framed within Strauss and Corbin's grounded theory paradigm model (Johns 1998a). Since then the MSR has been reflexively developed culminating in the 14th edition (Box 1.7). The cues within the MSR are arranged in a logical order, enabling a progression of thought through each cue. As I have noted, the cues are merely cues; the model is not intended to be prescriptive.

### *Bring the mind home*

This first MSR cue is not so much a reflective cue but a preparatory cue, to put the person in the best position to reflect. The idea of bringing the mind home was inspired by Sogyal Rinpoche, from his book *The Tibetan Book of Living and Dying*. He states (I have replaced his meditation with reflection):

'We are fragmented into so many different parts. We don't know who we really are, or what aspects of ourselves we should identify with or believe in. So many contradictory voices, dictates, and feelings fight for control over our inner lives that we find ourselves scattered everywhere, in all directions leaving no one at home. *Reflection then helps to bring the mind home* (p. 59). . . . Yet how hard it can be to turn our attention within! How easily we allow our old habits and set patterns to dominate us! Even though they bring us suffering, we accept them with almost fatalistic resignation, for we are so used to giving into them.' (p. 31, cited in Johns 2002, pp. 10–11)

Do you recognise yourself in Rinpoche's words? The focus on bringing the mind home helps to shift the balance of seeing reflection as a cognitive activity to a more meditative activity; a time of quiet contemplation to pay attention to the self: the way I think, feel and respond to situations, mindful of the gusts that will blow us off course, and skilled to hold the rudder fast when the currents would take us elsewhere.

Yet can we create this space within ourselves to bring the mind home? Although I carry a reflective journal about with me from day to day, I find I am too easily caught up in my busy day to pause and write. Maybe there are moments when I can scribble a few words. It is in the evening that I can take some time out to reflect. Perhaps some breathing exercises – following the breath in and following the breath out – will help to bring the mind home and release the tension that has accumulated during the day. After a few breaths, your mind may be crowded with thoughts. If so, don't resist them but let them come and go . . . it is clearing the debris of the day. Maybe some thoughts will linger, especially if associated with some feeling and perhaps that is what you need to reflect on and write about.

### *Description*

Some people like to tell their stories whilst others prefer to write them. Indeed many practitioners get stuck between telling their story and writing it. It is as if they hit a mental block. Perhaps the oral telling is more spontaneous whilst writing is more considered, more cognitive, more self-conscious. I sense the

presence of an internal censor at work in writing that tries to fit the description into learnt ways of writing that dismisses or denigrates feelings and imagination. For whatever reason, some people struggle to write. Perhaps telling stories is essentially a creative right-brain act whilst writing is essentially a left-brain activity and between the two sides of the brain the connections are fuzzy and censored. If so, the practitioner may need guidance to release the imaginative and creative power into her writing.

Schön (1983) suggests a difficulty even in saying what we know, that much of our knowing is tacit and not easily explainable:

'When we go about the spontaneous intuitive performance of the actions of everyday life, we show ourselves to be knowledgeable in a certain way. Often we cannot say what it is we know. When we try to describe it we find ourselves at a loss, or we produce descriptions that are obviously inappropriate. Our knowing is ordinarily tacit, implicit in our action and in our feel for the stuff with which we are dealing. It seems right to say that our knowing is in our doing.' (p. 49)

So, how might you write? Here is an example from my shift on Friday, written on Sunday morning.

Friday 25th April, 2003

A message on my mobile phone from Kay, the senior nurse at the hospice: could I do a late shift this afternoon; her words 'as you can tell I'm desperate.' I feel ambivalent about this request, part of me says 'yes' because I enjoy working at the hospice and want to help. Another part of me is uncertain: I want to work on this book! I am at a meeting with Jenny and share my dilemma. She laughs and says I am feeling guilty if I don't say yes. She's right. Am I caught in the 'caring trap' that Dickson (1982) describes? I phone the hospice and say I will come in to discuss it.

When I arrive Kay is interviewing. Phyllis, the unit administrator explains the situation – there is no registered nurse cover. So I agree to do it on the proviso that Susan, my wife, has no arrangements this evening. But I still feel ambivalent, not helped by the fact I have to borrow a uniform.

I join the shift report. Kay joins us. The unit is quiet. Ray died yesterday evening. I had spent Wednesday looking after him and his family. Meeting and talking with Mary, his wife was particularly poignant – her sense of emptiness that Ray was not at home. She had spent so much time looking after him, and now she was alone in the house and didn't know what to do. She said how she reached out in bed and his side was empty. Yesterday was also their wedding anniversary, adding to the poignancy. But dying and death spares nobody. Yet I feel okay. I had only touched the surface of this family.

Later I phone Susan. She is going out this evening but offers to cancel, 'needs must.' Now my guilt spirals . . . I ask her to decide for me but she refuses. I sense the chaos of the unit and its fragile covering arrangements. The unit is quiet but . . . I decide to stay and Susan will cancel her evening out. An ironic twist for Kay, who is also going out. 'Now I feel guilty!' she laughs.

So much guilt, we dwell in a sea of guilt . . . trapped by our caring ethic . . . and yet it is because we care deeply and accept a responsibility as part of a caring community. It is the poignancy of talking with Mary; a release of spirit and love. I feel okay about my guilt and know I would respond in the same way again, yet with more certainty.

## 22 Chapter 1

This was a very mundane event that I am sure many people can easily relate to. Yet within this description are very profound issues about myself and practice. Using the reflective cues I can now explore the situation more deeply if I feel it is significant. Some of the cues are already apparent within the description, reflecting that description has no boundaries but flows seamlessly within unfolding levels of reflection in the quest for understanding.

***How was I feeling and what made me feel that way?***

To re-iterate, reflection is most often triggered by negative or uncomfortable feelings (Boyd & Fales 1983). It seems natural to focus on negative experiences because these situations present themselves to consciousness. In general, practitioners are less likely to pay attention to experience that is normal simply because the experience does not project itself into conscious thought, or as Heidegger suggested, there is no breakdown. As practitioners become increasingly mindful of self within practice, then more experience becomes available for reflection, for example my own description above. I have also noted a shift of pattern as practitioners become more reflective: they reflect less on situations that show themselves as problematic and more on experiences that are self-affirming. Perhaps you have noted that within your own reflection?

A first year student nurse suggested to me that students always focused on negative experiences for two reasons; first, that was what teachers expected, and second, how can you reflect on a positive experience? He gave an example of a male patient thanking him for giving him a bath: 'What is there to reflect upon?'

For a moment I paused before this challenge and then a number of questions tumbled out:

- How did that make you feel?
- Is it important to feel like that?
- Why is it important to feel like that?
- How do you feel if patients don't thank you?
- Does it make you feel differently towards them (than those who do thank you)?
- If you feel negative towards the patient, are you less available?
- Do male patients like being bathed or touched by male nurses?
- How do you feel about bathing female patients?
- What theory might inform this discussion (for example the unpopular patient literature)?

It is like getting into a groove, tuning into the experience that appears, on the surface, as unproblematic. Scratch the surface and see what lies underneath. This example illustrates the need for guidance from another person perceptive enough to pose these types of questions, especially for practitioners who lack reflective or clinical experience, who have yet to develop their connected or separate voices. Yet what a rich teaching opportunity stemming from one line: *'A male patient thanked me for helping him bathe.'*

***What was I trying to achieve?***

This cue guides the practitioner to consider the purpose and meaning of her actions in terms of the way she grasped, interpreted and responded within the experience. The cue cuts across habitual action; so much of practice seems to be on auto-pilot: 'So why did I say that?' The cue brings one's personal and collective visions into focus.

***Did I respond effectively?***

Once the practitioner has clarified what she is trying to achieve, she can then consider whether her actions were effective. The cue challenges the practitioner to become mindful of her responses: how does she know whether her responses were effective or not? What criteria are used to make this judgement?

It is this cue that penetrates and surfaces any contradiction between our actions and our values. Yet what are our values? Are they valid? Are they shared by the patient?

***What were the consequences of my actions on the patient, others and myself?***

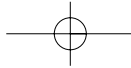
All actions have consequences for which the practitioner accepts responsibility. This cue guides the practitioner to contemplate the consequences of her actions on others and herself. It helps put the particular response (explored in the previous cue) into a wider perspective.

***How were others feeling? What made them feel that way?***

This cue guides the practitioner to appraise and develop their empathic connection with the other person, whether patient, family member or colleague. It challenges the practitioner to consider why the person felt as they did. So such questions as 'Why was she so angry?' 'Did I read her glance correctly?' 'Did she want me to do that?' might be in play.

***What factors influenced the way I was feeling, thinking or responding?***

This cue guides the practitioner to consider why she acted as she did. What factors influenced her? This always seems a difficult cue to respond to because so many factors that influence are deeply embodied and hence, not easily perceived. Yet it is an essential cue because unless we gain access to this self-understanding, it is difficult to bring about change in the way we think, feel and respond within particular situations. This is also quite a scary cue because it can require the person to look deep within themselves, unearthing, revealing influences that stem from social and cultural practices or past experiences that have left a scar in some way.



**Box 1.8** Grid for considering ‘What factors influenced my action?’

Expectations from self about how I should act? Conforming to normal practice?	Negative attitude towards the other?	Expectations from others to act in certain ways? Need to be valued by others?
Information/theory/research to act in a certain sort of way?	What factors influenced my actions?	Doing what was felt to be right? Guilty?
Emotional entanglement/over-identification? Strong feelings? Wrapped up in self-concern?		Misplaced concern? Loyalty to staff versus loyalty to patient?
Limited skills/discomfort to act in other ways? Stressed? Lack of confidence? Passive?	Time/priorities?	Anxious about ensuing conflict? Fear of sanction?

I have explicated common influencing factors into an influences grid (Box 1.8) as a guide for the practitioner to consider their impact within the particular experience, each of which leads the practitioner into a deeper reflection on the conditions of practice that may, on the surface, be taken for granted as normative.

***What knowledge did or might have informed me?***

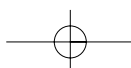
This cue challenges the practitioner to identify, assess and critique appropriate theory or research for its value to inform the particular experience being reflected upon. Undoubtedly, the effective practitioner is an informed practitioner and must take responsibility for ensuring her practice reflects ‘best practice’. Clearly this is a mighty onus on the individual practitioner given the vast amount of ‘knowledge’ and ‘evidence’ out there. An organisational response is required, for example developing standards of care and protocols (see Chapter 10). The relationship between practice and theory is developed further under theoretical framing.

***To what extent did I act for the best and in tune with my values? (Ethical mapping)***

This cue prompts the practitioner to pay attention to the ethical basis of her practice. To guide the practitioner to explore this cue I developed ethical mapping (Johns 1998b), shown in Box 1.9.

***The ethical map trail***

- (1) *Frame the dilemma*: most ethical issues can be reduced into a dilemma. For example, in Chapter 7 I use ethical mapping to consider whether Cathy should attend a patient’s funeral or attend a management meeting.

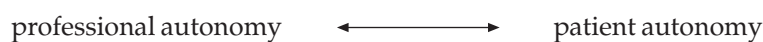


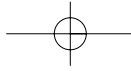


**Box 1.9** Ethical mapping (Johns 1998b)

Patient's/family's perspective	Who had authority to make the decision/act within the situation?	The doctor[s]' perspective
If there is conflict of perspectives/values, how might these be resolved?	The situation/dilemma	What ethical principles inform this situation? 'Beneficence, malevolence, autonomy, utilitarianism, duty and virtue, moral imperative'
The nurse[s]' perspective	Consider the power relationships/factors that determined the way the decision/action was actually taken	The organisation's perspective

- (2) *Consider the perspective of different people commencing with the nurse[s]' own perspectives:* by considering the perspectives of people involved within the experience the practitioner is challenged to see and understand other peoples' perspectives and to confront her own partial perspective. It is rather like a fish bowl: depending on where you are coming from, you will see something different from other positions; each perspective is a partial view. These perspectives are not necessarily motivated by what's best but by personal, professional or organisational interests. Ethical mapping encourages the practitioner to move from her own partial view to gain a global or helicopter view of the whole. Only then is she in a position to negotiate in terms of what's best. Understanding the perspectives of others will help the practitioner develop empathic skills, which is the basis for all therapeutic relationship (this point is developed in Chapter 2).
- (3) *Consider which ethical principles apply in terms of the best (ethically correct) decision:* having gained an understanding of different and partial perspectives, the practitioner can then consider the way ethical principles might inform the situation. The major ethical principles are those concerned with professional autonomy – beneficence and malevolence, the idea of doing good and avoiding harm that forms the basis of the professional relationship. The professional will always have the patient's best interests at heart and will act accordingly. The other side of this ethical coin is patient autonomy: the idea that the patient's right to be self-determining is respected. From this perspective, the role of the professional is to enable the person or patient to make the best decision. One common dilemma is truth-telling. Natural tension exists between these two ideas of autonomy along which most dilemmas can be framed:





## 26 Chapter 1

Another key ethical principle is utilitarianism: the idea of greatest good whereby the needs of the individual are secondary to the needs of society as a whole. This principle involves the use of resources, justice and equity. Common issues are the use of time and appreciating priorities. From this perspective we can draw another natural tension along which many dilemmas can be framed:

needs of the individual       $\longleftrightarrow$       needs of society

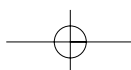
A further ethical principle is the idea of virtue or duty: the way the practitioner should conduct themselves befitting of the profession. An obvious example of this is that a nurse should always act in a caring manner. Nurses have a code of conduct that sets out the nurses' duty. Yet another ethical principle is Kant's moral imperative: 'do as you would be done for.' In other words imposing your own values into the situation – 'if that was my mother. . . .' The problem with this principle is that the patient is not your mother and that imposing such values may be misguided.

- (4) *Consider what conflict exists between perspectives/values and how these might be resolved:* having considered the different perspectives and ethical principles, the practitioner can consider if conflict exists and if so, how it might be best resolved considering the ethical principles. I have previously noted (Johns 2002):

'The map guides the practitioner(s) to view these competing perspectives from diverse ethical principles and to review the interface between ethical principle and the ethics of the situation (Cooper 1991).' (p. 15)

However, these principles are not prescriptive, they merely inform the thinking and counter the more subjective perspectives of the professionals involved. In an ideal world, professionals come together, including the patient as appropriate, to dialogue and find the best solution in terms of the patient's best interests.

- (5) *Consider who had the authority for making the decision/taking action:* this part of ethical mapping challenges the practitioner to consider her autonomy, authority and accountability for making and acting on decisions. According to Batey & Lewis (1982), autonomy has two dimensions; legitimate autonomy as set out in the person's job description, and discriminant authority – the autonomy the person believes she has. However, job descriptions are often vague and working in bureaucratic organisations seems to diminish discriminant autonomy, especially for groups of workers such as nurses who may perceive themselves as a subordinate workforce, which may also distort their perception of responsibility. Reflection always seeks to empower practitioners to expand their field of autonomy and counter any sense of oppression.
- (6) *Consider the power relationships/factors that determined the way the decision/action was actually taken:* in the real world, decisions are not necessarily made in terms of what's best for the patient or family, but in terms of power and fear of sanction. I explore the nature of power in relation to managing conflict in Chapter 7.



***How does this situation connect with previous experiences?***

An experience is not an isolated moment in time. It is part of a continuous stream of unfolding experiences. The cue challenges the practitioner to consider that if the experience being reflected on is linked to past experiences, how has the practitioner handled similar experiences in the past? Is there a pattern of response that the practitioner is locked into?

***How might I respond more effectively given this situation again?***

Besides linking the experience being reflected on with past experiences, this cue guides the practitioner to anticipate how they might respond to a similar situation in the future, challenging the practitioner to think laterally and imaginatively to see other options of response, even when they think they responded effectively. It is opening the shutters to other possibilities.

***What would be the consequences of alternative actions for the patient, others and myself?***

This cue follows on from the previous cue by challenging the practitioner to consider the possible consequences of responding in different ways within the particular situation. It helps the practitioner make judgements between different approaches. Considering each alternative way of responding is like planting a seed for responding in similar future situations (Margolis 1993). I develop this idea in Chapter 3 in relation to guiding reflection.

***How do I NOW feel about this experience?***

This cue draws the practitioner's attention to her feelings as a consequence of reflection. Is the practitioner left frustrated or angry or has she been able to work through the feelings in a positive way? What more does she need to do to mop up emotional mess and harness the residual bits of energy dissipated within the reflective space? How can she focus this energy for taking positive action based on insight gained? This work may be difficult to do without guidance from another person, another point I pick up in Chapter 3.

***Am I now more able to support myself and others better as a consequence?***

The penultimate cue challenges the practitioner to review their emotional and coping responses to the situations, and to reflect on the adequacy of their support systems within practice. As I have noted (Johns 2002):

'This cue often exposes impoverished support systems and challenges the practitioner to develop more effective systems.' (p. 17)

Stress depletes our energy, and it is our individual responsibility to keep ourselves in good shape to be available for therapeutic work. Yet so many of

28 *Chapter 1*

us carry loads of residual stress on our backs pulling us down, depleting our energy. Creating a therapeutic environment for practitioners as well as patients and families is explored in Chapter 7.

Before exploring the final cue – ‘Have I learnt from this experience?’ – consider the MSR cues in relation to my reflection concerning Ralph and Maisey I wrote one evening following a shift at the hospice.

## REFLECTIVE EXEMPLAR 1.1 – RALPH AND MAISEY

I am very tired this evening but my head is full of thoughts of Maisey and Ralph, so I decide to write . . . Ralph is 68. He has SVC obstruction secondary to cancer of his bronchus. His condition is precarious. He quickly goes blue if laid flat. Because of this a scan to ascertain the extent of the blockage was cancelled. (But then I ask myself, why was the scan booked anyway – the urge for certainty?) There is no treatment except the 16 mg dexamethasone he has been having over the past three days that has made no difference to his condition. At the review meeting today, I feel certain we will begin to reduce the dexamethasone. Ralph wants to go home to die to be amongst the familiar surroundings of his life. Shandra is arranging his discharge this morning, ensuring the district nurses are well prepared.

I follow Shandra down the corridor towards Ralph’s room. Ralph’s wife, Maisey greets us by the door. She has just had a jacuzzi bath after sleeping in the room next to Ralph. She says she is refreshed – sleep is not easy. Ralph is asleep so Shandra leaves the medication on the side for a while. He has difficulty taking the 8 small dexamethasone tablets besides his other pain relieving tablets, gabapentin and diclofenac. He has a fentanyl patch and takes oromorph to diminish his anxiety with breathlessness. Perhaps another route would be an idea for the dexamethasone? Shandra agrees.

Ralph looks comfortable propped in the bed so I sit and talk with Shandra and Maisey at the table outside his door. It is social chit chat about all sorts of things, especially about food and cooking. I feel slightly restless – a need to do something rather than just sit here. But the unit is quiet . . . I must focus on silencing myself and dwelling. After about 20 minutes, Shandra excuses herself to do something and I can focus the conversation with Maisey more towards herself. She is one of 16 children, her mother first had twins when she was 16 and had Maisey when she was 46, thirty years of constant childbirth. Maisey is the youngest at 66. Just 6 children remain alive, the eldest being 86.

They have a large house near Luton . . . Maisey says she will stay there after Ralph dies even though it’s so big, I think out of loyalty to Ralph. His presence will be in the house, and also because of her network of friends. Another part of her would like a more peaceful place to live away from the traffic.

Soon, I too give my excuses, it is hard to just sit for an hour. My body is tuned for more direct action at this time of the morning.

Later I help Shandra freshen Ralph. She asks me to hold him as we roll him so she can do a rectal examination. She has a sense that he is constipated which might further compromise his breathing. It will help him at home if we tackle any such problems now. But his rectum is empty. He has sores over his body and an elbow pressure wound drains copious fluid into a collection bag.

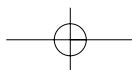
He struggles to stand and use a bottle. Indeed he is a large man . . . now we feel he should remain in bed so as not to compromise his breathing and provoke the SVC obstruction – we become more conservative, but does it really matter? Ralph agrees standing is now difficult although using a urinal in bed is not something he contemplates positively. A catheter is offered in view of him going home, but he declines, for the moment.

We finish his wash and tidy the room. I note his emaciated and dried legs. The skin is rough and dry and must feel uncomfortable. Another large pressure sore dressing covers one heel. I offer to moisturise his legs. Maisey says he has used aqueous cream but I suggest my reflexology cream may be nicer. It is my 'stock' jar with patchouli and frankincense. As before, I note the way Maisey and Ralph respond positively to the smell and rationale for these oils. For about 10 minutes I massage his legs and feet, moving my hands towards the heart, helping the sluggish circulation. Ralph is most appreciative.

Maisey sits close to Ralph . . . I sense Ralph's tears and then Maisey breaks away, tearful, and asks me to talk to him. She gestures through her tears and leaves the room. I know it's about the decision to go home. I sit with him, his lips tremble. He is caught in a dilemma: he does not want to be a burden to Maisey but he would like to be at home. He does not know what to do. We are silent and then he says he will stay. Just then Maisey comes back in, more composed. I inform her of Ralph's decision and immediately I know she is relieved because it takes an enormous pressure off her. She holds him, cradles him and says she will be here every minute with him. He needs this reassurance. I sense the fear rise in him and burst forth, his immense sense of losing Maisey, of being alone to die, fearing dying will be a lonely and frightening experience.

I observe them and feel such love. It is simply astonishing to be with people at such a moment. Maisey stands up and I sense the emotion flooding through her. I know it's right to offer a hug and she melts into my body and puts her arm around me . . . and for a moment or so I feel the tension ripple through her and then relax.

I inform Shandra that Ralph is staying, or at least he is staying for now. She goes to see him and Maisey as she must cease her discharge planning! I set up an aroma-stone with benzoin, lavender and frankincense. Ralph has a troublesome cough and I am mindful of using this approach with some success with Maxine [another patient]. I love the vanilla smell of benzoin. I talk through the benefits of the oils and they think the smell in the room will be beneficial for them all. As the warm smell percolates through the room I sense the spiritual dimension of the oils. Using the oils is also another sign to the family of our concern, that we are paying attention.



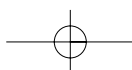
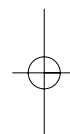
30 Chapter 1

After a teaching session away from the unit, I return to say goodbye to the family. They are gathered like a tribe around the table, six of them. I am reminded of being with Elsie, Carol’s mum with the family around the bed when I went to say goodbye. But today I feel I hover less on the periphery, that I dwell more within them even though I have not met four of the six people before. Perhaps I sense they know me because Maisey says, ‘We have been talking about you’ . . . (I guess in complimentary ways). I know she has been touched by my presence, just as she has touched the core of my being. Saying goodbye is never easy. Will I see them again? Will Ralph have died by Friday? I bless them with my love.

*Reflection*

This reflection was triggered by my interest in the idea of dwelling with a family as a family member approaches death. Consider the way I have addressed each of the MSR cues and the pattern they weave through the story. Is there a logical flow? I do not overtly use the model when I reflect because reflection has become so natural for me. Perhaps some of the cues are not addressed within the story. I can use the MSR as a list to check I have paid attention to all the cues.

<b>Reflective cue</b>	<b>Commentary</b>
What issues seem significant to pay attention to?	My uncertainty in responding to Ralph as Maisey rushed from the room distressed saying ‘speak to him’, framed within the bigger picture of ‘dwelling with’ this couple at this time.
How was I feeling and what made me feel that way?	Deep compassion; Anxiety: in responding appropriately and skilfully to ease their suffering that had burst out of its containment.
What was I trying to achieve?	To ease Ralph’s and Maisey’s suffering; to make them both feel more comfortable and less distressed in whatever way I could; to help them resolve their dilemma of where best for Ralph to die.
Did I respond effectively?	I think so – I am comfortable dwelling with patients and families as death gathers and using my massage and aromatherapy skills to create a sacred environment.
What were the consequences of my actions on the patient, others, and myself?	Ralph and the family were very appreciative of my actions. I felt I had achieved what I intended. I also know it was also a momentous time for Shandra being with this family, although I am uncertain how my actions affected her.
How were others feeling?	Full of emotion as Ralph slides towards death. Very positive towards me. I did wonder if I stepped on Shandra’s toes. I asked her and she reassured me that



I hadn't (I have been anxious about this before in my complementary therapist role).

What made them feel that way?

The immensity of the moment as death approaches.

What factors influenced the way I was feeling, thinking and responding?

Some fear of not responding well enough or messing it up (expectation from myself that I could respond effectively); not knowing the family; limited experience and skills and lack of confidence; doing what I felt was right – to ease suffering; stepping on Shandra's toes?

What knowledge did or might have informed me?

Certainly knowledge of different essential oils and their possibilities to help ease suffering – but being open to new possibilities with the oils. I know that dry skin is uncomfortable, I know massage is deeply relaxing. I was less certain about hugging Maisey as I did not know her well – but I was mindful of reading the signs well enough. I have been reflecting on my use of touch and reviewing the literature.

To what extent did I act for the best and in tune with my values?

I felt the tension between Ralph and Maisey and the way this tension created suffering. My action was to ease this suffering without undermining Ralph's autonomy.

How does this situation connect with previous experiences?

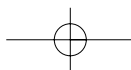
I had recently reflected on two other situations concerned with 'dwelling with' patients and families when death is certain and imminent. I have been developing a theory of 'dwelling with' and this experience contributed to my growing understanding. I was conscious of spending time with people in social chit chat and silence – overly concerned with my own comfort?

How might I respond differently given this situation again?

Such situations are very unpredictable – perhaps to be more comfortable with spending an hour with Maisey just chatting and steering the conversation more into Maisey's relationship with Ralph? But it is important not to delve too deep too quickly (is there theory to support that?).

What would be the consequences of alternative actions for the patient, others and myself?

Maisey and I would have 'dwelt better' – but only in theory – we were strangers first meeting under these circumstances – we needed to grope about to tune into each other. I felt that Maisey's head was elsewhere through most of the chit chat. I could have said no to Maisey's request or got Shandra to speak with Ralph but the moment would have been lost and I would have felt inadequate – does that matter? Yes. Responding was not about technique but being there.



32 Chapter 1

<p>How do I NOW feel about this experience?</p> <p>Am I now more able to support myself and others better as a consequence?</p> <p>Am I more able to realise desirable practice? (using appropriate frameworks).</p>	<p>Emotional but satisfied – it was a profound moment being with Ralph and Maisey.</p> <p>I would like to share this experience in supervision. Shandra was very supportive when we talked it through at the end of the shift. She more than I – I know she is also very close to this family. The experience enabled me to reflect deeper on my ability to ‘dwell with families’ as they face death. I am left wondering why I was restless talking so long with Maisey when it was so important for us to know each other and comforting for her not to be alone at this difficult crisis. My emotional turmoil revealed my lack of empathy and helped me become more mindful. My relationship with Shandra is strengthened.</p>
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**Have I learnt from this experience?**

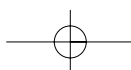
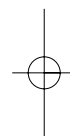
The final MSR cue, ‘Am I more able to realise desirable practice?’, guides the practitioner to consider ways in which learning through reflection can be adequately framed. In earlier editions of the MSR, up to and including the tenth edition (Johns 1998c), I utilised Carper’s fundamental ways of knowing (1978) as a valid way of framing learning (Box 1.2). Yet many practitioners struggled to interpret Carper’s ways of knowing in meaningful ways because it was too abstract and didn’t easily relate to the form of everyday practice. In response I advocate using the ‘Framing perspectives’ and the ‘Being Available’ templates as more accessible ways to frame learning (see Box 1.10).

In the MSR tenth edition, I had arranged the reflective cues to tune the practitioner into each of Carper’s ways of knowing. I ceased this arrangement for the thirteenth edition (Johns 2002), simply because I no longer advocated Carper to frame learning through reflection. For this book I have decided to re-integrate Carper into the margins of the MSR.

As I will reveal through the book, much of theory can be designed as reflective maps to position and monitor the development of self in particular aspects of practice, for example the development of assertiveness and managing conflict (see Chapter 7). The templates I offer to frame learning through reflection are not exclusive, and you might prefer other templates.

***Framing perspectives***

A comprehensive approach to frame learning through reflection is offered by framing perspectives. These are a set of lenses that represent the breadth of learning necessary for becoming an effective practitioner (Box 1.10). Besides being constructed from research analysis (Johns 1998a), they offer a more congruent way to view learning than using Carper’s patterns of knowing.





**Box 1.10** Framing perspectives – learning perspectives within dialogue (Johns 2004)

Framing perspective	The practitioner asks – How has this experience enabled me to:
<ul style="list-style-type: none"> <li>• Philosophical</li> </ul>	confront and clarify my beliefs and values that constitute desirable practice?
<ul style="list-style-type: none"> <li>• Role</li> </ul>	clarify my role boundaries and authority within role, and my power relationships with others?
<ul style="list-style-type: none"> <li>• Theoretical</li> </ul>	link theory with practice in meaningful ways?
<ul style="list-style-type: none"> <li>• Reality perspective</li> </ul>	appreciate and shift those forces that constrain my realisation of desirable practice (embodiment, tradition and power)?
<ul style="list-style-type: none"> <li>• Problem</li> </ul>	focus problem identification and resolution within the experience?
<ul style="list-style-type: none"> <li>• Temporal</li> </ul>	draw patterns with past experiences whilst anticipating how I might respond with appropriate skilful and ethical action in future?
<ul style="list-style-type: none"> <li>• Parallel process</li> </ul>	make connections between learning processes within my supervision process and my clinical practice?
<ul style="list-style-type: none"> <li>• Developmental</li> </ul>	develop my expertise using valid and appropriate frameworks (for example, the Being Available template)?

*Philosophical framing*

Beliefs and values ripple below the surface of every shared experience. These can be teased onto the surface and held up for scrutiny in order to consider any contradiction between the practitioner’s espoused vision of practice and the way she actually practises. Words like holistic can be explored for their meaning. Through philosophical framing the practitioner develops a more valid, robust and committed vision of practice.

*Role framing*

Each experience reflected on is framed by the practitioner’s role. As such role framing challenges the practitioner to clarify her role responsibility and authority to act within the specific situation being reflected on. Responsibility and subsequent accountability are diverse (Box 1.11). Is there role ambiguity and conflict? If so, what is its nature? In sharpening her understanding of her role, the practitioner can develop a sense of autonomy and respond with more certainty and tackle issues of role conflict.

*Theoretical framing*

The basic assumption is that the effective practitioner is an informed practitioner, able to assess, critique and assimilate into practice as appropriate, relevant knowledge. In a world that values evidence-based practice then clearly such ability is vital. However, as with Belenky *et al.*’s separate knower,

**Box 1.11** The diverse nature of practitioner responsibility and accountability

Accountable to	Rationale
The patient and family	To help them meet their health needs and support them through the medical response
Self	To act with integrity according to beliefs and values and to ensure self effectiveness
Society	To fulfil and enhance societal expectations of nursing
The organisation	To fulfil role responsibility
The profession	To justify actions within the guidelines of the UKCC code of conduct
Peers	To work in collaboration and mutually supportive ways to ensure patients and families receive congruent, consistent and effective care

all knowledge is viewed through a sceptical eye (Dewey 1933) – the reflective practitioner accepts nothing on face value. Knowledge merely informs, always needed to be interpreted for its relevance within the specific situation rather than applied as a prescription (Carper 1978). As Dewey notes:

‘Reflective action entails active and persistent consideration of any belief or supposed form of knowledge in the light of the grounds that support it and the consequences to which it leads.’ (cited in Tann 1993, p. 54)

Of course, this is the old chestnut of the theory–practice gap, as if these were two distinct types of knowing: ‘knowing how’ and ‘knowing that’. Reflection synthesises these ways of knowing into *praxis* – informed and committed knowing within the unfolding moment; knowing that is always contextual and subjective. How could it be otherwise?

*Reality perspective framing*

I call this perspective the ‘reality wall.’ It is the point where practitioners struggle to take action because of those factors, either embodied within themselves or embedded within patterns of relating, that constrain them. The intention of reality perspective framing is to acknowledge that it is not easy to shift the reality wall, but that’s okay – it is a real world and it’s tough sometimes. However, we can understand the barrier of reality whilst helping the practitioner to become empowered to act in more congruent ways.

Just because we can understand something doesn’t mean we can change it. But understanding it *is* the first step towards changing it. We learn to plot, become strategic, devise tactics. We are resolute, committed and patient.

*Problem framing*

Problem framing focuses the practitioner’s attention to the way she has framed and resolved particular problems that are evident within the reflection. Once

framed, the practitioner can see the problem for what it is and begin to consider ways of resolving it – to test in future practice. In this sense, reflection is very practical, and resembles an action-learning spiral of problem identification, understanding, resolution, subsequent action and reflection (Kemmis 1985).

*Temporal framing*

Reflection is never an isolated event but a moment of paying attention within the endless flow of experiences. This framing perspective guides the practitioner to consider how the present experience is informed by previous experiences. Are there patterns of behaviour evident? Do we keep falling into the same stream? Temporal framing facilitates the continuity of meaning between the present and past that Marris (1986) considers crucial in order to focus on the future in meaningful ways. If we are looking back at the past (with regret, resentment, disappointment, longing, fond memory) then we are not looking forward to new possibilities.

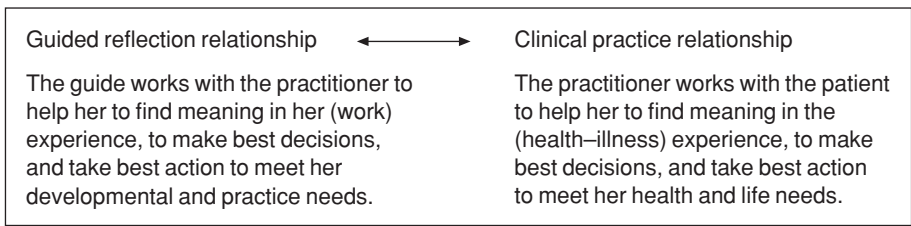
The other side of temporal framing is to anticipate the future – to be creative and imagine new ways of responding within situations. Over time, the practitioner can look back and reflexively plot a developmental journey through her experiences.

*Parallel process framing*

Parallel process framing perspective really only applies to situations where the practitioner has been guided. It invites the practitioner to consider the way the dynamics of guidance can inform her practice. It assumes the therapeutic relationship between the guide and the practitioner is a mirror for the therapeutic relationship between the practitioner and the patient or client. Box 1.12 shows this relationship.

The guide becomes a role model in the way she responds to the practitioner. As such the guide’s responses, for example the guide’s use of Heron’s Six-category intervention analysis (Box 5.2), can be analysed, viewed and rehearsed in terms of the practitioner’s practice.

**Box 1.12** The guided reflection/clinical practice link



**Box 1.13** Framing perspectives questions of Ralph and Maisey

- *Framing perspective*: How has my reflection about caring for Ralph and Maisey enabled me to . . .
- *Philosophical framing*: Is my vision of practice strengthened or developed?
- *Role framing*: Do I identify and resolve any role ambiguity or role conflict?
- *Theoretical framing*: Is my practice more informed?
- *Reality perspective framing*: Have I overcome constraints to practice more in tune with my vision?
- *Problem framing*: What problems have been resolved?
- *Temporal framing*: Have I drawn conclusions about responding more effectively?
- *Parallel process framing*: Are there patterns of learning between my experience and sharing it within supervision?
- *Developmental framing*: Am I more available to work with patients and relatives as a consequence of this reflection? (See also Box 2.6).

*Developmental framing*

How might I frame my realisation of desirable practice? The solution to this teasing question was to analyse the nature of desirable practice from over 500 experiences reflected on and shared by practitioners in guided reflection relationships. The result was the Being Available template (Johns 1998a). I explore this template in Chapter 2.

In Box 1.13 I use the framing perspectives to pose a number of questions to reflect on my learning from Ralph and Maisey's experience. I leave it to the reader to answer.

**Writing a reflective journal**

'What dark caves must you walk through? What do you fear? What are the things that make you hard and tighten your jaw? What memories still bite you? What situations or people do you avoid, postpone, run away from or aggressively blast through? These are your dark caves. Take the time to write these things down. Become intimate with your fears, for if you pretend they don't exist they are empowered, and then, they rule your life. Learn to walk through your fear. It is okay to be afraid and nervous and scared. You will not break. Each time you walk through your fear you become stronger and your fear becomes weaker. Each time you walk through your fear you learn more about yourself. What possibilities await you? Knowing the colours of your strengths, fears, challenges, and joy, what possibilities appear? Your dance can be danced with a variety of steps, a variety of expressions, a variety of emotion. Keep a journal of your strengths, fears, challenges and possibilities. Add to it when you can. Reflect on this often. Take the time to look over the results of the above discoveries. This is the mirror of your self. From this reflection, the final dance will appear.' (Blackwolf and Gina Jones 1996, pp. 52–3)

As a reflective practitioner I write reflections or stories of my practice in a journal. I wrote my reflection about caring for Maisey and Ralph the evening after the shift. I was tired but these thoughts and feelings were swimming in

my head and I knew I wanted to write about them and to explore further the idea of 'dwelling with' the family as death becomes imminent. As always I doubted myself: in the intensity of the moment had I responded well enough? I felt I had moved into a new space within my practice that felt exhilarating but also uncertain.

Although I carry my reflective journal around with me in my briefcase, I usually write my reflections in the evening when I can dwell with my thoughts and consider the events of the past few days with less distraction than at work. I always reflect after each visit to the hospice or following a community visit. Even the most ordinary events have great significance for the mindful practitioner. Yet, interestingly, I rarely reflect on my educational work as a university lecturer, at least in a written format. Part of the reason for this is that I use my practice reflections as educational material and research activity. I like to teach the palliative care students 'around the camp-fire' where I share my own stories of palliative care to trigger stories in others and to role model the art of reflective writing.

I know that 'just take some time out to reflect' sounds like easy advice, but when our lives are addicted to being busy, it may be hard to focus one's thoughts within rather than be scattered outside. As Rinpoche (1992) says:

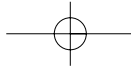
'We are fragmented into so many different parts. We don't know who we really are, or what aspects of ourselves we should identify with or believe in. So many contradictory voices, dictates, and feelings fight for control over our inner lives that we find ourselves scattered everywhere, in all directions, leaving nobody at home. Meditation (reflection) then helps to bring the mind home.' (p. 59)

Although Rinpoche was talking about meditation, reflection is a similar experience. If you consider that 'who I am' is the major therapeutic tool I use in my practice, then clearly I need to know myself well in order to use myself in the best therapeutic way. Reflection is about coming to know 'who I am', so I can refine and sharpen this tool for therapeutic work. As George Elliot wrote in *Daniel Deronda*, 'There is a great deal of unmapped country within us which would have to be taken into account in an explanation of our gusts and storms.' Reflection is mapping, charting the unknown self, to better recognise, understand and control these gusts and storms.

In his book *Awakenings*, Sacks (1976) says:

'In our study of our most complex sufferings and disorder of being, we are compelled to scrutinise the deepest, darkest, and most fearful parts of ourselves, the parts we strive to deny or not to see. The thoughts which are most difficult to grasp or express are those which awaken our strongest denials and our most profound intuitions.' (p. 15)

However, the deeper we go, the more defended we are likely to be, yet this is further reason why reflection may need to be guided to explore these depths within a trusting, caring relationship. It is our feelings that give access to the inner world, this is often a negative feeling or sense of discomfort about something that has happened during the day. So write a description of the feeling in your journal, in the middle of the page:



I feel angry

I am frustrated

I am sad

I feel so good

And then ask yourself some questions about the feeling – Why do I feel angry? Do I often feel angry in similar situations? Could I have not been angry? Etcetera.

Another approach is to simply write a story:

April 30

Today I felt angry at Jane, the junior nurse because I asked her to help a patient wash, but she ignored me and went to help someone else. I was puzzled why she did this. It made me feel angry but I could not challenge her . . . I just didn't want a fuss . . . but it made me angry . . . and I'm still angry at myself for letting her get away with it.

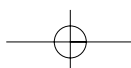
You might draw a line down the middle of the page and write the description in the left hand column and ask questions of the text in the right hand column. The questions flow naturally from the text yet are all grounded in the MSR cues:

Today I felt angry at Jane, the junior nurse because I asked her to help a patient wash, but she ignored me and went to help someone else. I was puzzled why she did this. It made me feel angry but I could not challenge her . . . I just didn't want a fuss . . . but it made me angry . . . and I'm still angry, at myself for letting her get away with it.  
I want to scream but it's bottled up inside me.

Why did Jane respond like that?  
How was she feeling?  
Does she normally respond like that?  
Was I sensitive enough in the way I asked her?  
Why am I so angry?  
How can I shift this anger?  
When I see her tomorrow, how will I feel?  
What do I need to do?  
Does transactional analysis help me understand the pattern of communication between us?

However, reflection does not need to be triggered by strong emotion, either negative or positive. As I have suggested, the most mundane experience can be a focus for reflection for the mindful practitioner. Reflection may be triggered by reading a publication or by interest in a specific aspect of care, as illustrated in my story of Ralph and Maisey.

Richardson (1994), in her review of 'the health diary' as a method for data collection, acknowledges that diaries can be structured or unstructured. The structured view focuses the research respondents to collect specific information about their life experience and illness management. The unstructured diary enables the respondents to focus on issues which they consider most significant. Structured diaries are easy and quick to write, thus making it more likely the diary is completed. This may be significant for people who are fatigued. However, some people may like to journal extensively in order to help find meaning in the illness and as a cathartic expression, for example the



journaling of Moira Vass (see Chapter 5). Structured diaries are also easy to analyse whereas unstructured diaries require coding and interpretation. Both types require respondents to be able to read and write in the same language, thus excluding people from participation.

### Therapeutic benefits of writing a reflective journal

The subtitle of Rachel Remen's (1996) book *Kitchen Table Wisdom* is 'Stories that heal', that in telling our stories, by reflecting on our experiences we can connect to something vital within us, something healing. In sharing our stories with others we realise we are connected to them and that we are not alone in the world. Connection is healing. Pennebaker and his various colleagues over many years have demonstrated the therapeutic benefit of journaling in well being, notably the benefit of connecting strong feelings to past traumatic events. Smyth *et al.* (1999) has developed this work to show the physical benefits of journaling on reducing symptoms in asthma and rheumatoid arthritis.

Smyth's (1998) review of the literature suggested that emotional expression has a salutary health effect, whereas emotional inhibition has a detrimental health effect. Emotional expression may take the form of writing or telling another person your story. Smyth cites Pennebaker *et al.*'s (1997) claim that:

'Written emotional expression leads to a transduction of the traumatic experience into a linguistic structure that promotes assimilation and understanding of the event, and reduces negative affect associated with thoughts of the event.' (p. 175)

Smyth's review highlighted that the ten review studies demonstrated significant superior health outcomes in health participants: psychological well being, physiological functioning, general functioning, reported health outcomes, but not for health behaviours. Smyth noted that these studies demonstrated that short-term distress was increased but is thought to be related to long-term improvement. Pennebaker *et al.* (1990) note:

'The present experiment, as well as others that we have conducted, found that writing about transition to college resulted in more negative moods and poorer psychological adjustment by the end of the first semester. Our experiment may have effectively stripped the normal defences away from the experimental subjects. With lowered defences, our subjects were forced to deal with many of their basic conflicts and fears about leaving home, changing roles, entering college.' (p. 536)

All indications from this study suggest that the power of confronting upsetting experiences reflects insight rather than cathartic processes. In follow-up questionnaires, for example, the overwhelming majority of the subjects spontaneously wrote that the value of the experimental condition derived from their achievement of a better understanding of their own thoughts, behaviours and moods. The stripping away of defence mechanisms means that practitioners and patients may need guidance to support them through the consequences of the writing experience (see Chapter 3).

## 40 Chapter 1

Pennebaker *et al.* (1987) investigated whether it made a difference if the respondents told or 'confessed' their stories to another person rather than into a microphone. 48 respondents were randomly assigned to either talking to a microphone or to another person hidden from view (as in a confessional box). The only noticeable difference was that SCL (a response to inhibition) was higher for people when talking to another person, suggesting that talking to another person was inhibiting. The researchers state:

'The studies indicate that a personality dimension is related to the degree of disclosure. Those rated as high disclosers could be characterised as individuals who exhibited more negative affect and were more emotionally expressive than were low disclosers. Low disclosers tended to depersonalise their disclosures, even by their own admission.' (p. 530)

This is a pertinent observation in that journaling and self-disclosure will vary in its benefit. Indeed for some people who cope by non-disclosure, journaling or confession may be detrimental, at least in the short term. However, as Pennebaker (1989) noted:

'When given the opportunity, people readily divulge their deepest and darkest secrets. Even though people report they have lived with these thoughts and feelings virtually every day, most note that they have actively held back from telling others about these fundamental parts of themselves. . . . Over the past several years, my colleagues and I have learned that confronting traumatic experiences can have meaningful physiological and psychological benefits. Conversely, not confiding significant experiences is associated with increased disease rates, ruminations and other difficulties.' (p. 223)

An important dimension to coping with stressors concerns the degree to which people discuss or confront traumas after their occurrence. Jourard (1971) for example, argued that self-disclosure of upsetting experiences serves as a basic human motive. As such, people naturally discuss daily and significant experiences with others. When talking about a trauma with others can strengthen social bonds, provide coping information and emotional support, and hasten an understanding of the event, the inability to talk with others can be unhealthy (p. 213).

Smyth *et al.* (1999) shifted Pennebaker's focus on healthy college students to patients experiencing the specific chronic illness states of asthma and rheumatoid arthritis (RA). They sampled 112 patients with asthma or rheumatoid arthritis and assigned them in random controlled trial (RCT) groups to write either about the most stressful event of their lives or about neutral topics. Outcomes were evaluated at 2 weeks, 2 months and 4 months after writing. They reported that patients with mild to moderately severe asthma or rheumatoid arthritis who wrote about stressful life experiences had clinically relevant changes in health status at 4 months, compared with those in the control group. These gains were beyond those attributable to the standard medical care that all participants were receiving. For the asthma patients, the primary outcome measure was forced expiratory volume in one second (FEV<sub>1</sub>). An improvement is measured as 15% improvement in functioning.



Evaluations of RA patients were made with a structured interview completed by the treating rheumatologist, rating diagnostic symptoms, global assessment of disease activity, symptom severity, distribution of pain, tenderness, swelling throughout the affected joints, presence and severity of deformities, assessment of daily living capacity, and general psychosocial functioning. This was based on a categorical scale (asymptomatic/mild/moderate/severe/very severe), and a shift in category gave on overall rating. There was 47% improvement in experimental groups, compared with 24% in control groups. Improvement was maintained in asthma patients whereas the change for RA patients was not evidenced until the 4-month period, suggesting that underlying physiological processes differ in different chronic processes.

The study by Smyth *et al.* indicates that writing about illness experience does reduce physical symptoms. Alexander (1998), in her role as writer-in-residence at a hospice noted:

'Writing is no solution to pain or illness. It cannot cure or heal physical damage but it can help a person to feel whole again, a human being with a story to tell.' (p. 178)

Alexander's role was to help others to express themselves in words. Whether words can heal is an interesting challenge and the focus for her present study.

## Reflection as humanities

There are a number of poems scattered through this book that capture the poignancy and intimacy of the moment, expressing the self beyond a rational or cognitive level of knowing. Writing a poem is a release of tension, an expression of compassion, that honours self and other and the connection between you.

On the reflective practice course I direct at the University of Luton, my colleague Val Young does the *umbrella exercise*, asking students to write about themselves as an umbrella or as the wind. The results always astound the students. It is liberation from the bonds of rationality, a setting free in the world to be an artist, creative, imaginative, empathic, uncensored and caring. Often, after writing a poem, practitioners say that they do not know where their words have come from. Many are astonished that they can write poetry, as if it is some untapped, latent potential within us all. Yet in a technology-driven world, the latent artist may be buried under the demand for the rational, scientific, masculine perspective.

In one workshop I painted a reflection on my feelings after the death of Iris, a patient I had given reflexology to over two years. The painting was simply the six colours painted horizontally that represented each of the major chakras I balance as part of reflexology. In the middle of the painting I portrayed a gaping dark grey hole that represented the disruption of the energy fields with Iris's death and my sense of loss. Inside the hole I spread the shavings from sharpening the colour pencils, each shaving representing the fragments of Iris's life, the memories of being with her collected together. I wrote the poem *Shavings* to accompany the painting.

42 *Chapter 1***Shavings**

I sense the black hole  
 Blown open inside  
 Its angst leaking out  
 Across the anguished soul

I sense the shavings of your life  
 Fragments of wholeness  
 Reflecting all the different colours  
 that flow within

like broken bits they float  
 about; unconnected  
 like bits of self  
 now lost

yet I see your colours bright  
 that surround the gloom  
 my hand connects you  
 to sense your beauty.

*Christopher Johns*

Richmond (1995) offers a Jungian perspective, that aesthetic expression taps the collective unconscious:

'a more profound layer than the personal unconscious and containing inherited patterns of behaviour revealed in the Universal symbolic images of phantasies, myths, dreams, or works of art.' (p. 218)

Perhaps that is where the words flow from, shaped into a beautiful creation. It is this sense of creativity that softens suffering and enables people to learn through reflection. As Parker (2002) writes:

'Art and aesthetic expression unite us and contribute to our wholeness. They are essential means of communication and move us all toward increased well being.' (p. 104)

Undoubtedly, caring is a form of aesthetic expression (Wainwright 2000) that both reflects and nurtures caring. Art opens up a creative possibility that moves beyond, although the practitioner may need a guiding hand to move beyond barriers that portray art form as soft and flakey.

One risk of introducing models of reflection is to structure writing to stifle the spontaneous flow of words. It is easy to get locked into the technology of reflection, 'how to do it', simply because we live in a technological world that demands explanatory models. Poetry is like taking a short cut to the unconscious, by-passing the cognitive realm. As such, aesthetic expression balances the more cognitive approaches to reflection, a more holistic approach that draws on and uses all the senses and tap the deep pool of tacit knowing (Polanyi 1958).

A number of studies have used art and poetry to help practitioners find meaning in their experiences of being with suffering patients (Begley 1996; Brodersen 2001; Eifried *et al.* 2000; Parker 2002; Vaught-Alexander 1994). Of course this is no surprise, because it is the essence of art therapy (Mayo 1996; Tyler 1998). These studies reflect the way humanities can open a space where practitioners can dwell with their own vulnerability within a safe space, where expressions of vulnerability can be expressed in whatever form and learnt from. As McNiff (1992, cited by Picard *et al.* (1999)) eloquently puts it, '*Whenever illness is associated with a loss of soul, the arts emerge spontaneously as remedies.*' Put another way, whenever activity is related to the soul, the arts emerge spontaneously as soul food.

Wagner (1999) interviewed 18 nurses for their reflections of family impact on the dying experience. She then reduced these experiences into a set of categories using fragments of the nurses' reflections to justify each category. In doing so, I felt she lost the meaning in these nurses' stories. However, Wagner then re-interpreted the nurses' words into poetry 'as a way of knowing subjectively and inter-subjectively the fullest meaning of the data' (p. 21). Her poetry reflects a deeper level of interpretation beyond cognition. In my mind it heals the story and makes it possible to connect with the experience because it is whole, it is felt rather than read.

## Evaluating reflection

Reflective practice has been criticised for its lack of definition, modes of implementation and for its unproven benefit (Mackintosh 1998). Mackintosh singles out the Burford reflective model for criticism. She states:

*'The benefits of reflection are largely unaddressed by the literature (that is beyond unsubstantiated claims), and instead the underlying assumption appears to be that reflection will improve nursing care or the nursing profession in some intangible way. This is demonstrated by Bailey (1995), who although describing the introduction of reflection into a critical area and claiming that an improvement in problem-solving skills occurred, gives no evidence that the quality of care was improved in any way. These failings can also be found in much of the literature describing the Burford reflection in nursing model (Johns 1996a, b) which attempts to integrate reflective practice into a clinically grounded nursing model through use of a series of 'cues'. Much of the published evidence regarding the model's impact on clinical practice appears to be based on personal anecdote, and again, evidence in support of its impact on patient care is of a mainly qualitative and descriptive nature.'* (p. 556) [italics my inclusion]

Of course reflective accounts are subjective and singular. The accounts within the *Burford NDU model: Caring in Practice* (Johns 1994) were not cited in the above references. Yet in this book there are four collaborating accounts from Burford practitioners and accounts from four other nursing units besides Burford, accounts that testify to the impact of the Burford model on clinical practice. In other words, Mackintosh reviews the literature with her own partial eye, seeing or interpreting what she wants to read to support

her prejudice against reflective accounts and qualitative methodologies. As Wilber (1998) highlights, different paradigms have their own rules for injunction as to what counts as the truth, and who better to know their own truth than the practitioner? To dispute that truth would mean that every survey, interview and psychometric test is flawed, tainted with the 'suspicion of authenticity', and perhaps more so because the truth is obscured behind an objective illusion. As I explore in Chapter 3, the role of the guide is to help the practitioner see herself more objectively and to challenge the basis for perceptions and assumptions.

The limitations of reflection as a mode of learning have been highlighted by, amongst others, Platzer *et al.* (2000). Platzer *et al.* noted that students may be resistant to revealing self, a point also highlighted by Cotton (2001) that reflection becomes a type of surveillance, assessment and control. Yet education has always been a socialisation process. Where teachers use reflection from a teacher-centred perspective, then it may be resisted. Platzer *et al.* further note that embodied ways of learning and organisational culture impose tremendous barriers to reflecting on and learning from experience. Without doubt there are barriers, but the barriers are a focus for learning and shifting, both within self and within the organisational culture. Real education isn't necessarily easy. Students may prefer to be fed what they need to know but is that an adequate preparation for developing critical thinkers? The MSR has been tested and found to be beneficial in enabling students to develop self-awareness and caring potential (Novelestskey-Rosenthal & Solomon 2001).

Burton (2000) has noted:

'It will be argued that reflective theory and practice has not yet been adequately tested and there is a pressing need for evidence to demonstrate irrefutably the effectiveness of reflection on nursing practice, particularly with respect to patient outcomes.' (p. 1009)

Burton challenges why the UKCC and ENB insist that nurses at all levels of experience reflect, when the evidence to support its benefits is unsubstantial. Perhaps she should ask, why do people think in the first place and read research findings? Yet Burton's words, again like those of Mackintosh, reveal the way people who inhabit a behavioural paradigm view reflection. They impose their own rules of injunction without appreciating the nature of reflection.

### **Reflection is *not* primarily a technology to produce better patient outcomes**

Reflection is essentially about personal growth, and its impact on personal growth can only be known through the stories people tell. As narratives can exquisitely illuminate, the impact on patient care shines through yet not in any reductionist sense. For example see the research narratives published in Johns (2002).