From Reflective Practice to Performance - Becoming Storytellers of Homeless Health Practice

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Members of the Queen’s Nursing Institute, Health and Homeless Advisory Committee
A gathering call ....
Specialist Nurses

...honing practice stories from the streets to the boardroom
Welcome to this workshop

- Please settle into your seat
- In a moment we shall begin to tell stories from our homelessness practice
- You will be invited to dialogue with us about the stories
- Theory surrounding story and performance will be illuminated
- In the second half hour of this workshop you will be guided to write your own practice story using the Six Dialogical Movements
- Our aim is to use story to illuminate homeless practice as an act of social justice for homeless people
Social Justice

Social justice is a matter of life and death. We can all easily recognise the health inequalities experienced by people for whom absolute poverty is a daily reality

(There is) very little reference in studies of patients stories in clinical encounters, to their daily experiences of living under condition of poverty, oppression or social exclusion

How is this possible?

(Mishler, 2005 p.438)
Why Tell a Story?

Stories take listeners to places they could never go themselves
(Okri, 1997 p23)

Story performed as social action
make sense of complex systems
(Mattingly, 1998 p6/7)

Narrative grasps the fractured world of homelessness to accommodate the complexity of experience
(Fordham, 2009 p12)
Story is creating
Story is sustaining
Story is transforming
Story is life-giving

(Johns 2010 professorial inaugural lecture)
Stories, in some ways, create themselves …

the time will come when we realise that stories choose us to bring them into being

for the profound needs of humankind

(Okri, 1997, p46)
The need to honour chaos stories is both moral and ethical. Until the chaos narrative is honoured, the world in all its possibilities is being denied.

(Frank 1995 p109)
Jan’s Story

Bandaging Wounds

My Journey with John
Photography
by
Nik Roche

Poetry
by
Jan Keauffling
Maria’s story

Torture

My Journey with Heidi
(Part 1)
18 Chapters

Positioning self in role

Clinical role in a Public Health career
Develop research skills

Becoming available

Seattle Developments

1. What knowledge would have informed me
Insights
- If I was old and going into a room where activity was absent - Is there a way to know why people are dying?

2. Dialogue with peers to check a deeper insight
- Less about being asking
- Insight into emerging

3. What would your narrative provide
- For group to ask themselves
- Have narrative

Looking forward

1. Show with leadership

- Keep close system
- Build upon a scale you need

• Henderson (2001)
• Johns (2009) and Senge (2005)
• Gadow (1980)
• [Fordham (2012)]
The Model of Structured Reflection
(Johns, 2009)

Forward thinking cues...

- What insights have I gained?
- What other knowledge would inform my insights?
- Am I now more able to realise desirable practice (…in homeless health care)?
Heidi's Story
Episode 2
Advent,
A Time of Waiting...
TBC ....

Photography
by
Maria Fordham

Poetry
by
Maria Fordham
Through the homeless health narrative, hidden truths drift quietly into the soul of the reader or listener; in so doing, it achieves a transformative social justice value

(Fordham, 2012 inspired by Okri, 1995)
We now invite you to dialogue with us....

Dialogue, a stream of meaning flowing among us, through us and between us

(Bohm 1996, p6)
How did the stories make you feel?

Did they ‘draw you in’ to:

- effectively illuminate the **complexity** of homelessness?
- illuminate the **suffering** of the person experiencing homelessness in a holistic way?
- illuminate the therapeutic process and/or **skills** **required** in the situation?
The theory ...

- Methodology (briefly)
- Method
# PhD: Philosophical Methodological Framework
(Fordham, 2012, adapted from Johns 2008)

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<th>Reflective Practice Theory</th>
<th>Narrative Inquiry</th>
<th>Nursing Theory</th>
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<td>Autoethnography</td>
<td><strong>Narrative as a Journey of Self-inquiry and Transformation</strong></td>
<td>Aesthetics: Photography, Collage</td>
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<td>Autobiography</td>
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<td>Empowerment Theory:</td>
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<td>Critical Social Sciences</td>
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<td>Ancient Wisdom and Philosophy</td>
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<td>Feminist theory</td>
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<td>Hermeneutics</td>
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Performance (auto)ethnography

Auto-ethnography

A self narrative that critiques the situatedness of self with others in social context ...

Good autoethnography is a provocative weave between story and theory  
(Spry, 2001, 713)
Aesthetics

- Art
- Poetry
- Music
- Photography
Method:
The Six Dialogical Movements
(Johns, 2009)

- First developed by Johns (Palliative care nursing)
- Jarrett (Physical disability nursing)
- Fordham (Health and homelessness)
- Foster (Psychiatric nursing)
- Graham (Nurse lecturer)
Gaining insights through reflection on practice experience

*From Significance* → *To Insight*

Reflecting on practice experience within a deepening hermeneutic circle
Method
Six Dialogical Movements [1-3] (Johns, 2009)

1. Dialogue with self. Write a story from practice in your journal, detailing experiences (Authenticity)

2. Dialogue with the story using MSR as an objective and disciplined process to gain tentative insights (Systematic reflection)

3. Dialogue with wider literature sources to position tentative insights (Construct validity)
Six Dialogical Movements [4-6]

4. Dialogue with others/reflective guides to deepen insights
   (Face validity)

5. Dialogue with the emerging text to weave the narrative into a coherent whole
   (Rhizomatic validity; face validity)

6. Dialogue between the narrative and others facilitating social actions to inform a wider audience
   (Performance validity)
What challenges do you anticipate from using this method for your own practice stories?
Benefits:
Developing insights and new knowledge in ‘The Four Quadrants of Homeless Health Practice’ (Fordham, 2012)
Ethics

- Duty of care to mask the identity of others mentioned in reflections (Do no harm/confidentiality)
- Self inquiry is an authentic process of understanding practice (Autonomy and Beneficence)
- Self inquiry leads to positive outcomes for practitioners and others (Beneficence)
- Emphasis on utilitarianism – some risk can be tolerated in terms of the greater good (The area of consent)

(Johns, 2002; Fay, 1987)
Our Vision

- To work with you to gather stories from practice and to develop them towards publication and/or performance.

- To gauge your interest in reflective guidance gatherings in health and homelessness locally, regionally or nationally where we dialogue together using yours/our practice stories.
So ... let's go. Be playful in your writing!
Workshop Practice

Aim:
To begin to dialogue about your practice using the Six Dialogical Movements
1\textsuperscript{st} Movement – Dialogue with self [Journal]
2\textsuperscript{nd} Movement – Dialogue with journal story systematically [MSR]
3\textsuperscript{rd} Movement – Dialogue with wider literature
4\textsuperscript{th} Movement – Dialogue with others/guides/peers
5\textsuperscript{th} Movement – Dialogue with texts to weave a narrative
6\textsuperscript{th} Movement – Dialogue to inform a wider audience
1st DM
Write spontaneously in your journal about a significant practice experience (5 mins)

- Relax – empty your mind ..... 

- Let a recent significant practice experience come to mind

- On one half of your paper write spontaneously about it, paying attention to as much detail as possible:
  
sounds, smells, how you were feeling, how others were feeling, what you said, what others said.
Use a model of reflection systematically (5 mins)

The Model of Structured Reflection (Johns, 2009)

- Bring the mind home
- Focus on a description of an experience that seems significant in some way
- What issues are significant to pay attention to?
- How do I interpret the way people were feeling and why they felt that way?
- How was I feeling and what made me feel that way?
- What was I trying to achieve and did I respond effectively? (aesthetics)
- What were the consequences of my actions on the patient, others, myself?
- What factors influence the way I was/am feeling, thinking and responding to this situation? (personal)
MSR cues continued

- To what extent did I act for the best and in tune with my values? (ethical)
- How does this situation connect with previous experiences? (personal)
- How might I reframe the situation and respond more effectively given this situation again? (reflexivity)
- What would be the consequences of alternative actions for the patient, others and myself?
- What factors might constrain me responding in new ways?
- How do I NOW feel about this experience?
- Am I more able to support myself and others better as a consequence?
- What insights have I gained?
- Am I more able to realise desirable practice? (Framing Perspectives)
<table>
<thead>
<tr>
<th>I: Own subjective knowledge (Authenticity)</th>
<th>It: Empirical knowledge (EBP)</th>
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<tbody>
<tr>
<td>We: Cultural and world view</td>
<td>Its: Social systems and environment (NHS, Housing, Social Services, Voluntary organisations)</td>
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</table>

Four Quadrants of Consciousness Model (Wilber, 1998)
4th DM Dialogue with guides and peers to deepen insights (7 mins)

Anam Cara – soul friendship

The anam cara brings epistemological* integration and healing. You look and see and understand differently. Initially this may be awkward but it gradually refines our sensibility and transform your way of being in the world

(O'Donohue, 1997:38)

* the branch of philosophy that studies the nature of knowledge
5th Write a coherent narrative

6th Perform the narrative with a wider audience as a form of social justice......
Homeless Health Nurses

By using a constructive voice to tell our stories, we contribute to a momentum of change, culminating in becoming political which is a nursing act of social justice

(Fordham, 2012)

Working for Social Justice
Stories have to be told or they die and when they die, we can't remember who we are or why we're here.

Sue Monk Kidd, The Secret Life of Bees
Thank you!
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References


Developing insights: Advanced Nursing Practice (Fordham 2012)

Clinical nursing + Public health nursing focus → Towards commissioning
Attitudes

By our very attitude to the other person, we help to shape one another’s world. By our attitude to the other person we help to determine the scope and hue of his world; we make it large or small, bright or drab, rich or dull, threatening or secure

(Logstrup, 1997:18)

- Compassionate response is a chosen one (Rankin and DeLashmutt, 2006)
- Deserving and undeserving patient (Kelly et al, 1982)
- Dirty work heartsink patients (Shaw, 2007)
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<tr>
<th>The Homeless Person</th>
<th>Childhood Trigger</th>
<th>Presenting Homeless /health Concerns</th>
<th>Towards preventing adult homelessness</th>
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<tr>
<td>Robert 23 yrs (Yr 1 - Text 7)</td>
<td>Health and family focus is on twin sister, Emma, 15, receiving palliative care for leukaemia. Robert finds relief in 'street-drugs' with friends.</td>
<td>• Chest pain  • Anxiety  • Survivor guilt; feelings of worthlessness  • Heroine and cannabis misuse  • Smoking  • Paranoia  • Nine episodes of offending - no family history of offending</td>
<td>• Child in Need/CAF  • Primary care: Macmillan team working with children's 0-19 team  • Children's bereavement counselling/family counselling  • Family drug intervention programmes</td>
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<tr>
<td>Heidi 49 yrs (Yr 1- Text 8)</td>
<td>Maternal mental ill-health and domestic violence culminates in mother’s suicide. (Heidi finds mother with plastic bag over her head). Heidi introduced to child prostitution by her father</td>
<td>• Sprained ankle  • Personality Disorder  • Alcoholism  • One episode of offending</td>
<td>• Child in Need/Safeguarding  • Primary Care: Mental health services working with 0-19 children's services in Primary care  • Children's counselling services</td>
</tr>
<tr>
<td>Lucy 16 yrs (Yr 2 - Text 15)</td>
<td>Parental mental ill health/ sibling has learning disability. Lucy experienced ‘daily beatings’ - believing it was normal until she discussed it with school friends aged 10</td>
<td>• Extensive cutting (self harm)  • Depression  • Suicidal tendencies  • Sexual health</td>
<td>• Child in Need/Safeguarding  • Primary care: Joint working between mental team, learning disability team and Children's 0-19 team  • CAMH outreach/transition into adult services model</td>
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