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## Through the Looking Glass Space to New Ways of Knowing: A Personal Research Narrative

### Abstract

This article describes how writing personal research narratives during my doctoral research journey challenged my role as a health professional and my personal beliefs and values in fundamental ways. In qualitative narrative inquiry, the reflexive account of the research experience is a key element in conducting ethical, rigorous, and meaningful forms of qualitative research. However, as a novice researcher, I was unprepared for the unlearning journey I experienced during the research process. This uncomfortable experience cut to the core of my identity by dismantling unexamined belief and value systems that lay dormant and hidden from my everyday consciousness as a health professional. In the spirit of transparency, reflexivity and “good” qualitative research, this article presents an explicit account of my exquisite and sometimes excruciating reflexive research journey that profoundly changed how I relate and work with people. I believe health care professionals should adopt a narrative view of experience that creates the “looking glass space” to locate their own stories within the broader socio-cultural and historical context of their lives, especially in relation to their health professional identity. Exchanging diminishing dialogue with deeper dialogue honours both the complexities of young peoples’ lives and social worlds and encompasses socially-conscious methodologies of promise and hope.

### Keywords

Autoethnography, Qualitative Research, Narrative, Writing as a Method of Inquiry, Personal Narrative, Unlearning

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## Through the *Looking Glass Space* to New Ways of Knowing: A Personal Research Narrative

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*This article describes how writing personal research narratives during my doctoral research journey challenged my role as a health professional and my personal beliefs and values in fundamental ways. In qualitative narrative inquiry, the reflexive account of the research experience is a key element in conducting ethical, rigorous, and meaningful forms of qualitative research. However, as a novice researcher, I was unprepared for the unlearning journey I experienced during the research process. This uncomfortable experience cut to the core of my identity by dismantling unexamined belief and value systems that lay dormant and hidden from my everyday consciousness as a health professional. In the spirit of transparency, reflexivity and “good” qualitative research, this article presents an explicit account of my exquisite and sometimes excruciating reflexive research journey that profoundly changed how I relate and work with people. I believe health care professionals should adopt a narrative view of experience that creates the “looking glass space” to locate their own stories within the broader socio-cultural and historical context of their lives, especially in relation to their health professional identity. Exchanging diminishing dialogue with deeper dialogue honours both the complexities of young peoples’ lives and social worlds and encompasses socially-conscious methodologies of promise and hope. Keywords: Autoethnography, Qualitative Research, Narrative, Writing as a Method of Inquiry, Personal Narrative, Unlearning*

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My journey to becoming a qualitative researcher evolved over four years and was fuelled by my desire to seek, hear, and share “real” stories of young mothers in a West Australian, semi-rural community. My previous role as a community youth health nurse, working with young pregnant women, was the source of this desire. Like many in this field, I sought to be in a “position of service to those among us who suffer most” (Clandinin & Rosiek, 2007, p. 64). While listening to pregnant and young mothers’ stories, I became aware of the significant and complex issues young mothers face, especially while trying to navigate their way through a myriad of biological, psychosocial, cognitive, and cultural changes. I felt a strong sense of injustice, witnessing the ways in which young people’s needs were not being adequately addressed by community health care services. It frustrated me that there was a lack of youth-friendly, accessible, and appropriate health services. In addition, young women’s narratives are restricted by health care discourse that constructs *teenage pregnancy* as “a disease, as expensive, as resisting mainstream culture and as reproducing disadvantage through reproduction” (Breheny & Stephens, 2010, p. 309). It concerned me that the negative discourse could become a dominant voice in these young women’s minds and play a prescriptive role in shaping their lives and future life options as young women and mothers. The purpose of my doctoral research was to explore how young women understand, experience, and make sense of pregnancy and motherhood and to provide a vehicle for young mothers to speak back and challenge the diminishing and damaging preconceptions and stereotypes that surround their young lives and influence their identities.

To my surprise, however, my research journey not only led me to hear the voices of young mothers but also illuminated the reciprocal and co-constructed process of qualitative research which seeks to witness, acknowledge, and share human stories. In order to portray the richness of this journey, my supervisors encouraged me to write about my personal experiences throughout the research process. This was part of the reflexive process, an essential element of the rigor required in qualitative research. Creswell (2006) defines reflexivity as the consistent conscious examination of one's own professional and personal biases, values, and experiences. Interweaving my personal narrative with the stories of the women I "studied," led me to see myself in new ways and even to the discovery of what feels like my authentic voice as a health professional, researcher, woman, and mother. Human and humane discoveries like these are at the heart of personally reflexive research yet are alien to more traditional, "objective," and removed approaches to how we study human life. The methodological and conceptual lens guiding my research was always "becoming" and evolving throughout the research process. Although I drew substantially on interpretative ethnographic methods of data collection, including participant observation early in my fieldwork, my focus quickly shifted to the young women's experience as lived and told in stories, as changes in my understanding deepened, the research organically unfolded as narrative inquiry. I have since learned that honouring and locating myself and my story in the wider personal, historical, sociological context is a form of autoethnography. Autoethnographers aim to produce accessible, meaningful and often evocative research that is grounded in personal experience, which can expose readers to issues of identity politics and silenced voices that have the potential to deepen our empathy towards people who are different from us (Ellis & Bochner, 2000). This narrative based approach "fits" better with my personal and professional worldview and perceptions, because it embodies the aesthetics of human experience and honors people's stories and lives. Narrative inquiries are often autobiographical, as interests and motivations emerge out of narrating our personal and professional experiences. Working from a narrative inquiry space and writing what Nash (2004) describes as *scholarly personal narratives* allowed me to "admit the full range of human experience into formal scholarly writing" (p. 29).

### **The Power of Story**

If you want to know me, then you must know my story, for my story defines who I am. And if I want to know myself, to gain insight into the meaning of my own life, then I, too, must come to know my own story. (McAdams, 1993, p. 11)

As humans we cast our identity in a narrative form as a way of expressing ourselves and our world to one another. I was consciously introduced to the power of storytelling through viewing the influential artwork of Paul Gauguin, a French artist who, in 1897, posed some fundamental questions in his artwork titled: "Where do we come from? Who are we? Where are we going?" With this painting in mind and searching for some answers to personal questions that arose during my research journey, I discovered Jerome Bruner's (2004) seminal work *Life as Narrative*. He suggests that people make sense of their past, present, and future lives by the roles they see themselves playing in the unfolding storylines of their lives. A constructivist worldview suggests that these "stories" are not fictions (in the sense that they are untrue) but rather constructed accounts of key life events and our interactions with others (Bruner, 2004). I began to wonder: if life is lived through the stories we tell, then it must also potentially allow individuals to adapt, shift, and modify their stories, transforming their lived experiences. This goes to the very heart of the power of story, a vehicle with the potential to

(re)order, (re)structure, and (re)direct one's life in more meaningful and integrated ways (Goodson & Gill, 2011).

The act of telling my personal research story stimulated an exploration of who I am—where I have been, where I am now, and where I am going. Telling my story allowed me to re-author an alternative and preferred life story. In essence, my narrative encounter and understanding was a hermeneutical project with transformation at its heart because it encourages a “dialogue with the world” that shapes individual meanings and understandings of human experiences (Goodson & Gill, 2011, p. 74). McAdams (1993) suggests that this is a key stage in the development of human identity, in particular the process of story to “formulate personally meaningful answers to ideological questions so that one's identity can be built on a stable foundation” (p. 36). Narrative was therefore both a method of inquiry as well as the phenomenon as I was leading a storied life under research. I hope sharing and reflexively analysing my story will speak to and invite other novice researchers to broaden their horizons and embrace the tension between chaos and equanimity that occurs in “doing” narrative research. Taking this personal leap inverts traditional modes of research and requires that our understandings and writing begin “from the inside out, rather than from the outside in” (Nash, 2004, p. 59).

### **Becoming an Emotional Participant**

Just as I was starting to open up a wider lens on the world by acknowledging my humanness and emotionality as a co-participant in the research process, I discovered that I was pregnant. An interweaving of the dual reflections and voices of our experiences, both the young mothers and my own began to emerge when Lucy, a young woman turned to me and said:

as women we both made choices; it doesn't matter if you are twenty or forty when you become a mum, you are learning and feeling your way through just the same. (Field notes 11<sup>th</sup> May 2010)

Lucy's words reverberated in my thoughts and heart, as I unintentionally became a “research insider,” with firsthand perspective on the pregnancy experience. Many researchers have documented how stories resonated with their own personal experiences and how this can evoke an emotional response in the researcher (Luttrell, 2003; Lysaght, 2009). Lysaght (2009) refers to this as becoming an “emotional participant” and recommends using such experiences to add another dimension and enrich the data analysis, contributing to a new “way of knowing” that may not have occurred without *inside* understanding. My own developing awareness of this new “way of knowing” (feeling) were captured in my field notes:

Today I had an *ah ha moment*: you know those valuable fleeting glimpses of unconscious, unexamined thought patterns or behaviours which provide clarity, insight and a new way of seeing the world around us. Over the last few weeks at the community house, I observed many of the young pregnant women engaging in unhealthy behaviours; eating certain foods that should be avoided due to the risk of listeria, smoking cigarettes and consuming large amounts of caffeinated coffee. Over the weekend, I found out that I am pregnant and it was already impacting how I viewed the young women. While making a cup of tea before the program, I dunked the tea bag twice in the hot water and then discarded it to weaken the caffeine levels. As I walked out of the kitchen to join the young mothers in the program, I felt different. Why do I re-dunk my tea bag and they don't? I started to question whether my previous observations had been

non-judgmental. Do I see myself as “better” or more “informed” than these women? Have I been observing the young women through my middle class, health professional *I want to fix you* world view lens with silent judgment? How has this affected my data collection so far? Maybe the young women I find the hardest to connect with have picked up on this? No wonder these young women have reported a mistrust of health authorities, and quietly displayed acts of resistance by not engaging in mainstream health and social service. No wonder we have got it so wrong! (Field notes 22<sup>nd</sup> July 2010)

The tea bag incident provided the catalyst for “losing the plot,” my plot! I realized that I had been collecting data through a health professional research lens and it had limited my ability to really see and understand what life was really like for young mothers. I had wanted to be open throughout the research process. However, I realized that I had not been able to suspend all of my own biases, and subsequently, I had not been able to see or hear the young mothers’ stories. Holloway and Freshwater (2007) suggest that this experience lies at the heart of narrative research:

Narrative research creates an opportunity not just to understand vulnerability in its diversity and complexity (content of the relationship), it also provides scope for an approach to research that appreciates and recognises vulnerability, thus making visible the power dynamic and at its best exposing the uncertain reality contained within the ethical processes (equity of the relationship). Finally, narrative research with vulnerable individuals permits nurses to engage with their own vulnerability, person to person and human to human (dynamic of relationship). (p. 710)

Such reflexivity has the power to enhance health professionals’ understandings of vulnerable groups and identify constraining Western empirical research systems that dominate our training, thinking and current health care policy and practice. Denzin and Lincoln (2008) claim that many narrative researchers have written about similar experiences, displaying their vulnerability in research texts. Personally reflexive and vulnerable approaches to research have been criticized, namely as being self-indulgent or airing dirty laundry that is not appealing to the wider research community. However, I refute this argument by suggesting that researchers need to more fully understand themselves in order to understand how they interpret other people’s stories. This argument is affirmed by Lutrell (2003) who states “what we are able to know depends upon attention to interpersonal encounters and how well we know ourselves in our ethnographic relationships” (pp. 152-153). I felt in many ways that to honour the stories of the women I spoke with, I had to honour my own, including reflecting on my pre-conceptions and prejudices that may have been a result of my middle-class, white upbringing, among many other cultural/personal influences. I began the difficult, unsettling work of acknowledging and examining the belief systems that had structured and shaped my life, my relationships, and my role as a health professional:

Today I realised that my initial resistance to accept myself as an emotional participant in my interactions with the young mothers, was directly related to my own story--a story and unexamined belief system that valued objective, empirical knowledge over subjectivity and human emotion. This narrative experience allowed me to embrace my humanness and emotion, initiating a deep learning journey to becoming a more authentic person. (Field notes 27<sup>th</sup> July 2010)

I came to realise that current health care culture and systems trains health professionals to be experts in health, a role that encompasses and values objectivity over emotionality. This expert persona is constantly reinforced, since we are paid to be the health expert, a role that is possible because of the value we place on health knowledge, knowledge that has been acquired from years of study and professional development. I discovered, however, that while we may value this expert and paternalistic approach to care, the young mothers do not. This premise leads me to question “Whose knowledge is of value?” I have come to learn that if we continue to view ourselves as health experts by directing the lives of others, than our expert knowledge risks becoming meaningless to many of the most vulnerable populations we serve, only standing as a barrier to connectedness and the fundamental elements required in developing relational, transformative, and healing relationships with individuals and communities. Although I lectured at university about social justice, primary health care, and health inequities that exist in communities, an unconscious part of myself was still substantially influenced by an individualised view of health, whereby the responsibility for health is on the individual. A healthy sense of shame prevailed as the contradiction in my own *thinking* and *being* became clear. I had been unconsciously perpetuating the inequities young women face, the very thing that I wanted to challenge within my community. This is described by Gadamer (as cited in Goodson & Gill, 2011, p. 79) as part of the nature of the narrative encounter, as previously:

Undetected biases and prejudices, uninterpreted and un-negotiated meaning, as well as new insights, might thus progressively unfold about both the person and about what *speaks* to the person regarding their efforts and their life goals. This unfolding can be surprising, disquieting, challenging or inspiring.

Exposing my personal “secret stories” and making them public is all part of the “doing” of narrative inquiry. As Clandinin and Connelly (2000) make clear, it is impossible “as researcher to stay silent or to present a kind of perfect, idealized, inquiring, moralizing self” (p. 62). The exquisite irony inherent in this challenge was that the young mothers I thought I was “better or more informed than,” ended up “being the experts” and me the naïve learner. This revelation or as Bochner and Ellis (1992) refer to as “epiphanies” irrevocably deepened and enriched my own personal and professional narrative. Following this experience, I was somewhat relieved when my reading on narrative research led me to Connelly and Clandinin’s seminal work (as cited in Goodson & Gill, 2011), whose work draws parallels between the researchers’s unravelling story and the goals of narrative therapy suggesting perhaps the researcher herself:

Derive meaning from the stories and the storying process, and can begin to *create a new story of self, which changes the meaning of the event, its description, and its significance for the larger life story the person may be trying to live*. It is also a dialogic process in which the researcher constructs and re-constructs her own identity (p. 24).

According to White (2007), a leading narrative therapist, narrative work involves separating the self from the story, so the story resides in an external space. This space not only provides the means for communicating our lives with one another (through storytelling) but also presents a strong foundation for change and growth in the storyteller by encouraging the storyteller to explore alternative understandings and re-script different stories for/of their lives. The interface between narrative research and narrative therapy (acts of telling and retelling stories) has been documented by several research scholars including Goodson and Gill (2011)

and Lysaght (2009). This dissolution of my own story allowed me to more fully bear witness to the young mothers' stories. A moment from my field notes demonstrates this transition and shift in awareness and relation:

I can't explain the *shift* that has occurred in my relationships with the young women. It is like my new way of seeing has released my invisible mask of hidden judgment that was contributing to the young mothers' wariness of me. Today, as I sit in the circle, I am energetically included as *one of them*, a trusted peer as they share their stories. Why? Is it because I am hearing and seeing through a new lens or have the young women unconsciously felt my energy shift and, therefore, feel safe and open in their communication with me and others in the group. Either way, I am excited as I sit and embrace their generosity and absorb the richness and breadth of their stories. I am on an inward bound journey to a deeper understanding of my own story so that I can truly bear witness to their lived experiences (Field notes 29<sup>th</sup> July 2010).

Following this probing insight, the tables turned, the young women's stories took on new meanings and they were teaching me. I experienced beyond cognitive knowing the power of reciprocity in research as I began to honour and locate my story within the research relationship, a process Richardson and St. Pierre (2008) claim "can evoke deeper parts of the self, heal wounds, enhance the sense of self--or even alter one's sense of identity" (p. 482).

### **My unlearning Journey**

As revealed above in my personal research narrative, storying one's own research experience has the power to dislodge and dissolve fixed understandings. The strength of using a narrative view of the research experience lies in the co-constructed nature of narrative inquiry, a process that encourages a wide angled lens that moves us beyond the status quo that privileges the voices of health professionals to an open, relational approach which consults, considers and understands young mothers as the *experts* of their own lives.

Aranda and Street (2001) refer to this as the creation of multi-voiced narratives that encourage often-invisible issues to become visible, giving new insights and understandings of taken for granted complexities of nursing practice.

Below I will share my reflective field notes that were written after I exited the field, a concept Goodson and Gill (2011) refer to as the *afterlife* of the narrative encounter. These notes are important, as they expose the radical shift that occurred in my gradual progression toward finally being willing to unlearn:

As my research journey progressed, I came to realize that just like the young women I was researching, I, too, had a closed, socially scripted story, especially in relation to my role as a health professional. I realized that I had not previously been open to an alternate view of young mothers because I had been working within a health service that reinforced the negative or problematic construction of young mothers. My perception of young mothers was not just informed by my middle class upbringing that values the "socially proper age chronology and order" of becoming a mother (Lesko, 2001) but had also been substantially influenced by the health professional-fix it-intervention focus that views myself as the expert and the young mother as the "problem." Adopting a narrative view of experience created the "looking glass space" I needed to dissolve my own story and discover this unexamined and unknown part of myself. The



acknowledgement and dissolution of my own story allowed my narrative to *open*, creating the catalyst for my own transformational learning journey to occur. Seeing the world through a narrative lens has profoundly changed how I relate to people. I have come to learn that my previous way of working with people does not feel right for me anymore. As I discovered during this research journey there are many different ways of seeing the world and there are many different knowledges to draw from to inform my community health nursing practice. Looking at the world through a narrative view of experience feels right for me. I do not want to be a functionary technician that compartmentalizes, standardizes, and works *on* people, I want to work *with* people and influence their journey through thoughtful questioning and a sensitive approach that, above all, values their stories and affirms their existence. My goal of being a genuine advocate for young mothers will only occur by being willing to challenge my thinking embrace the personal by uncovering the hidden politics behind why we keep getting it wrong. Unexpectedly, it was the narrative encounter with the young mothers in my study that helped cure my occupational blindness (Ittelson, 2007) by weaving threads of humility, alternate understanding, and a deeper sense of authenticity into the richness of my own personal narrative (Personal narratives, March 2012).

Social and health care providers and researchers need to be willing to share more stories, personal feelings, and research experiences that expose, explore, and explain how the intellectual and emotional work of transformative “unlearning” occurs. This has been recommended by Macdonald (2002) who calls for nurses to engage in active dialogue and create “communities of learners” (p. 170) that are willing to potentially shake the collective health professional identity in order to challenges out-dated knowledge and support more holistic models of care. Based on my own experience, this shift can occur by adopting a narrative view of experience that exposes and acknowledges the multiple realities and truths that exist in human life worlds, a process Freire (2004, p. 27) describes as a “rereading of the world.” However, the process of *unlearning* is not an easy undertaking and has been described by Rushmer and Davies (2004) as a process of pain and transformation. They argue that deep unlearning is experienced when one is confronted by a significant gap between what one believes the world to be and what one sees and hears. An event that requires a sharp spilt from the past, which “shocks, hurts and threatens” (Rushmer & Davies, 2004, p. ii12) deeply held values and beliefs about the world and ourselves.

Unfortunately, I believe that many health care professionals, and health services, do not have the “looking glass spaces” to examine and locate their own stories within the broader socio-cultural and historical context of their lives, especially in relation to their health professional identity. Consequently, opportunities for health care providers to undergo the transformational process of “unlearning” are limited for three reasons. Firstly, the culture of current health care belief systems trains health professionals to be *experts* in health, a role that encompasses and values objectivity over emotionality. This health professional *expert* persona is entrenched and reinforced daily in financial rewards, and social and health care systems, structures and policy that reinforce unhealthy hierarchical power relationships. Negative impact of the *expert* health professional persona has been debated before in Lenrow’s (1978) work, highlighting the dilemmas of professional helping and Teresa Hagan’s (1986) research in the United Kingdom, interviewing people who were excluded from the medical system. Hagan’s findings suggest that a clash of values between middle class health professionals and what she refers to as “interviewing the downtrodden,” may be responsible for patients’ disengagement. Unfortunately, however, their findings and important implications for

enhancing health care practice went unheard. Recommending the process of unlearning does not disavow the value of a health professional's knowledge and experience, nor should it diminish the caring work inherent in the everyday health professional practice.

Secondly, health care organisations are resistant to the unlearning process that would potentially create cultural change due to organisational memories that value stability, predictability, and certainty over the pain caused by transformational unlearning (Rushmer & Davies, 2004). This is further compounded by the hierarchical nature of health care systems, whereby valuable narrative knowledge (from practitioners) is diluted by senior "health experts" who resist risking the vulnerability entailed by the unlearning process. Thirdly, this process requires hard work and includes the willingness to question safe and familiar aspects of the health professional's identity, one that is firmly based on maintaining power and *expert* authority. This may be attributed to cognitive dissonance, whereby people dismiss data (consciously or unconsciously) that conflicts with their worldview or laziness as mental models and mindset that encompass patterns of thinking provide a shortcut to seeing and understanding the world. This presents an attractive way of compartmentalizing and dealing with new and challenging events (Rushmer & Davies, 2004), especially in the ever changing health care environment.

### Conclusion

Writing scholarly personal narratives during my doctoral research created a platform for self-exploration, a space for narration and reflection which challenged me to locate my story within the wider social, cultural, and historical context of my personal and professional life. Based on my research experience, a narrative view of experience stimulates deep questions that invite and prompt self-reflection and the examination of one's life as lived and told in stories (Goodson & Gill, 2011). Unfortunately, current health care policy and practice is firmly based from an *expert* perspective that works in direct conflict with the open-mindedness and vulnerability that is crucial to the unlearning process. Employing narrative in the process of researching and working with others constitutes a powerful pedagogic site of learning and personal development by including dialogic conversations and interactions that are "open," whereby stories and interpretations are exchanged, recounted, and reconstructed reciprocally (Goodson & Gill, 2011).

Writing personal research narratives fosters the elements required for unlearning including openness to vulnerability--a willingness to listen to explore new ideas and feelings, and to act in new ways (Rushmer & Davies, 2004, p. ii13). The act of storying research experiences can assist researchers and/or practitioners in recognising unhealthy power relationships and has the potential to de-institutionalize relationships. As I discovered, unexpected forms of knowledge can result from multi-voiced narratives that encourage an inter-dependent deep learning journey. The act of acknowledging, telling, and sharing stories promotes personal and professional growth by creating a different "looking glass" space in which to safely view and reflect on our personal and professional stories. In line with Charon's (2006) perspective on narrative medicine, narrative acts replenish instead of deplete us, "for our suffering helps our patients to bear theirs. Its own reward, this care envelops us all with meaning, with grace, with courage, and with joy" (p. 236). As health care practitioners and researchers, it is a matter of *care* and *integrity* that we welcome the challenging process of opening our own narratives to ensure we honour the complexities of our own and other's human lives through the stories we have the courage to tell and share.

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Gabrielle Brand, RN, PhD, is a lecturer in Health Professional Education at The University of Western Australia. This article is based on her personal research journey during her doctoral candidature at the School of Health Professions at Murdoch University in Western Australia. Ethics approval was granted by the University Ethics committee. Correspondence regarding this article can be addressed directly to: Gabrielle Brand at, Education Centre, Faculty of Medicine, Dentistry and Health Sciences, The University of Western Australia, M515, 35 Stirling Hwy, Crawley WA 6009 Australia or Email: Gabrielle.Brand@uwa.edu.au

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