



CRITICAL REFLECTION ON PRACTICE DEVELOPMENT

Emerging from physiotherapy practice, masters-level education and returning to practice: a critical reflection based on Mezirow's transformative learning theory

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Abstract

Background and context: In order to integrate knowledge derived from the best available evidence-based practice, autonomous practitioners – including physiotherapists – need to challenge their routine ways of working. Masters-level education encourages critical and independent thinking and offers a means to acquire knowledge that has the potential to improve practice. Mezirow's transformative learning theory fosters critical reflection and considers how our preconceptions and assumptions may influence practice. A combination of critical reflection and masters-level education may therefore be of value in developing evidence-based practice.

Aim: To demonstrate the value of critical reflection and masters-level education, particularly within physiotherapy practice, through the application of Mezirow's transformative learning theory.

Conclusion: By reflecting on my own 'disorientating dilemma' I was able to combine Mezirow's transformative learning theory and the knowledge gained during my masters degree to guide my learning. This personal experience has had a positive impact on my practice, particularly when working with people living with dementia.

Implications for practice: Mezirow's approach to critical reflection features throughout the nursing literature but has not been the model of choice for reflective practice in physiotherapy. His transformative learning theory may therefore be a useful model by which physiotherapists, as well as other practitioners, critically reflect on their practice and understand the impact on practice of their presuppositions, and may offer a means to integrate evidence from good-quality research.

Keywords: Masters degree, Mezirow, physiotherapy, reflection, evidence

Introduction

It is important that workers in an evolving healthcare system, including physiotherapists, adopt an attitude of critical and autonomous thinking, which Mezirow (1997) suggests can be developed through 'transformative learning'. Taylor (2009) describes this as a process of affecting change to our taken-for-granted assumptions and habitual ways of doing things to make our practice more inclusive and truthful. It has been suggested that practitioners are accepting of the reality of their daily work, concentrating efforts on effective and efficient means to problem-solve without reflecting on their practice (Williams, 2001). Physiotherapists, like other healthcare professionals, are expected to integrate the best research evidence with clinical expertise and patient choice by engaging in evidence-

based practice (Chartered Society of Physiotherapy, 2015). Evidence-based practice has been defined as ‘the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients’ (Sackett et al., 1996, p 1).

Integrating evidence from high-quality research requires ‘well thought-out’ strategies (McDonald and Nadash, 2003, p 52) and an appreciation that a fundamental distinction exists between understanding evidence and applying it in practice (Harbecke, 2012). Phair (2009) therefore highlighted the importance of practitioners’ ability not only to articulate why they adopt a particular practice but also to demonstrate how their practice has been transformed.

Masters-level education facilitates the acquisition of knowledge by encouraging independent learning and critical thinking; however, this education alone does not ‘transform’ practice. It has also been suggested that masters education is not always embraced in the workplace, partly due to misconceptions surrounding its value and the lack of research to support and justify this learning (Stathopoulos and Harrison, 2003).

The desire to challenge my routine ways of working and improve evidence-based practice, particularly when working with people living with dementia, triggered me to step out of physiotherapy practice and undertake a masters degree in clinical research. As part of the degree, this reflection focuses on using a concise interpretation of the original 10 phases of Mezirow’s (1991) transformative learning theory (Table 1, page 3). I aim to offer a personal and critically reflective account of my experiences by illustrating the cycle of my transformative learning experience – emerging from physiotherapy practice, undertaking a masters degree and returning to the clinical environment.

Table 1: Mezirow's 10 phases in the transformative process

Phase	My reflection and experiences
1: A disorientating dilemma	Are my perceptions about dementia impacting on my ability to implement best practice when treating people living with dementia?
2: A self-examination – with feelings of guilt, anger, shame	I realised that I lacked knowledge about dementia, and adopted a 'medical model' approach to treating people living with dementia – now acknowledged as an 'old culture of care' (Epp, 2003)
3: A critical assessment of assumptions	Do my preconceptions about dementia display any elements of stigma? Are my assumptions of dementia based on facts and a good understanding of the condition?
4: Recognition that one's discontent and the process of transformation are shared	Reassured that other people shared a common unease with regard to their practice. Opening up discussions with others to share experiences and discuss ways to facilitate positive change
5: Exploration of options for new roles, relationships and actions	Looking beyond my masters degree towards integrating new knowledge and evidence into the workplace and working with others to improve practice
6: Planning a course of action	Looking at resources and training opportunities, and developing presentations to disseminate knowledge and education
7: Acquiring knowledge and skills for implementing the plan	Completing assignments and modules on masters course. Attending training specific to dementia. Being involved in research relating to dementia
8: Provisional trying of new roles	Back in the workplace, I have put into action what I have learned, which has given me confidence. This has resulted in a new role as a frailty practitioner
9: Building self-confidence and competence in new roles and relationships	Feedback from colleagues and physiotherapy students
10: A reintegration of one's life on the basis of conditions dictated by one's new perspectives	Career development and future prospects

Self-examination of my 'meaning perspectives' and tackling my 'disorientating dilemma'

Mezirow (1997) stated that as experiencing human beings, we should learn to make our own interpretations through transformative learning rather than acting on the purposes, beliefs, judgments and feelings of others. The process of transformative learning begins with 'perspective transformation', a process of fundamental change in 'meaning perspectives' or 'frames of reference' described as the taken-for-granted and habitual expectations that we have of the world (Mezirow, 1997).

Mezirow et al. (2009) claim that all adult learning takes place through meaning perspectives, which are developed through childhood experiences and reinforced through the process of socialisation and learning from others. It has been argued that meaning perspectives 'operate at the preconscious level whereby people are unaware of the power their belief systems have on shaping themselves and their world' (Callin, 1996, p 29). It is therefore uncommon for individuals to stop and 'examine the presuppositions upon which habits of expectation are predicted' (Mezirow, 1991, p 15; MacIntosh and Wiggins, 1998). Mezirow (1991) suggests that the more these habits are reinforced, the more embedded and resistant to change they become.

Identifying my meaning perspectives and the process of transformative learning began early in the masters degree programme when I was introduced to the terms paradigm, epistemology and ontology. These terms resonate with my understanding of Mezirow's (1991) meaning perspectives. A paradigm is accepted as a worldview or a 'framework' that is a way of looking at the world (Saks and Allsop, 2011, p19). Epistemology is narrowly defined as the study of knowledge and justified belief, and ontology is the study of the nature of being or reality (Zalta, 2014).

Reflection on my meaning perspectives showed I lacked sufficient knowledge and awareness of dementia to implement best practice, and that I adopted a positivist paradigm in my approach to dementia. This may be recognised as viewing dementia as a disorder, a set of clinical symptoms and a medical condition requiring a medical perspective on treatment (British Psychological Society, 2007). This has been described as the 'medical model' of dementia and is now considered an 'old culture of care', that reduces dementia to a biomedical phenomenon (Epp, 2003 p14). The disorientating dilemma is said to be the 'catalyst' for 'perspective transformation' (Mezirow, 1991, p 189). It occurred for me when I was invited to self-examine or reflect on my practice when working with people living with dementia. The dilemma is whether to reinforce the existing worldview or to begin the process of revision (Harbecke, 2012).

Self-examination has been equated to looking at our reflection in a mirror (MacIntosh and Wiggins, 1998). Providing a mirror is suggested to 'begin the development of critically aware thinkers' (Galbraith, 1991, p 130, cited in MacIntosh and Wiggins, 1998). An awareness of our meaning perspectives can trigger disorientating dilemmas. If the way we view the world no longer resonates with what we had previously perceived as true, this can provoke critical or self-reflection. (Mezirow et al., 2009).

Through self-examination I began to question whether my knowledge, awareness and preconceptions of dementia were positively or negatively impacting on my practice and whether they displayed any elements of stigma. I felt that my lack of knowledge and some misunderstandings that I held about dementia impacted on my perception of those with the condition and resulted in an attitude that these individuals lacked rehabilitation potential. Self-examination of my meaning perspectives resulted in an emotional reflection; I became aware of feelings of guilt and shame, which, according to Mezirow's theory, are often associated with disorientating dilemmas. The need to critically reflect on my meaning perspectives and tackle my disorientating dilemma triggered the third phase of Mezirow's transformative process.

A critical reflection of assumptions, epistemology, ontology and paradigm

Being enlightened by a new way of thinking about knowledge, reality and my own assumptions through the masters degree programme sparked off critical reflection on the integrity of my deeply held assumptions and led me to reflect on whether my usual way of working with people living with dementia was acceptable. Definitions of reflection are said to emphasise 'purposeful critical analysis of knowledge and experience, in order to achieve deeper meaning and understanding' (Mann et al., 2009, p 597). It has been suggested that the capacity for reflection is an essential characteristic of professional competence (Mann et al., 2009) and critical reflection can therefore support professional development (Mezirow, 1994; Morrow, 2009). The importance of reflection and reflective practice is well documented in the literature, and there are many models of reflection (Mann et al., 2009). Kolb (1984) and Gibbs (1988) offer models that can introduce the concept of reflection into practice and are arguably more accessible to less experienced practitioners than Mezirow's theory. Engaging in a process of critical reflection is crucial to transformative learning, which enables the reflective practitioner to deconstruct their taken-for-granted norms and practices, challenge preconceptions and develop new ways of working with supportive evidence (Mezirow, 1997; Phair, 2009). This level of critical thinking is part of the expectation of a masters-level student and therefore may offer a more appropriate model for the more experienced practitioner to develop their reflective practice.

Three types of reflection have been suggested by Mezirow (1991):

- Content reflection (an examination of the description of the problem)
- Process reflection (checking on the problem-solving strategies)
- Premise reflection (questioning the problem)

Reflecting on content does not necessarily promote learning because it involves recalling what we already know (Cranton, 1996). Nevertheless, content reflection was an important first step in my learning process in that it prompted me to question whether I had been too accepting of my intuition when working with patients living with dementia.

Acknowledging my meaning perspectives regarding my perceptions of dementia and a new understanding of my approach to dementia in my practice enabled me to move towards process reflection. I previously identified with the positivist paradigm, as someone who may have subscribed to René Descartes' (1596-1650) philosophy. Descartes believed that trust could be placed on knowledge derived through deduction using the natural sciences (Hoffman, 2002). A Cartesian philosophical approach would therefore doubt sense perception and suggest that we cannot trust that our senses convey true information. This realist ontology, where there is an objective reality and representational epistemology, where a person can 'know reality' through objective verification (Hoffman, 2002) did not hold once I began the process of critical reflection. According to Epp (2003), focusing dementia care on the disease process does not attend to personhood, treats the person as an object and is damaging to the person. I therefore concluded that a change in perspective was needed to enable resolution of my disorientating dilemma.

Having critically reflected on the philosophy surrounding different approaches to knowledge, reality and research, a shift in my paradigm occurred. I have therefore developed a sceptical and questioning approach, embracing the transition from a previously positivist viewpoint to a more holistic and interpretative paradigm. Mezirow's theory has been compared with a constructivist position – a belief that sense experience is in fact central to meaning and therefore key to learning (Mezirow, 1991). In keeping with the philosophy of Immanuel Kant (1724-1804), my ontological and epistemological approach now accepts that as we journey through life, we soak up experiences, interpreting our surroundings, the objects we sense and the people we meet, and deriving our own unique meaning knowledge and experience. Our 'life map' unfolds as we continue to encounter objects of experience and conduct social exchanges with others. This interpretative paradigm results in the belief that there is no one true reality, but only what we see as our own reality. According to this perspective, I understand that my perception of dementia has been developed through my knowledge and awareness of the disorder and through personal experiences of meeting people living with dementia. Developing greater experience and deeper knowledge and awareness therefore had the potential to improve my practice.

Using process reflection to critically reflect on my approach to best physiotherapy practice in dementia care prompted a shift in my approach from the medical model of care towards the 'social model of dementia' (British Psychological Society, 2007). Tom Kitwood was a prominent figure in the development of this model, whereby dementia is seen more as a construct of various aspects of the person, rather than just a disease process. Central to adopting the social model is communicating effectively and respectfully with those living with dementia. Kitwood (1997, p 47) identified 17 poor communication processes that he called 'malignant social psychology', such as 'treachery', 'infantilisation' and 'objectification', saying these have a negative impact on 'personhood'. Kitwood (1997, p 8) defined personhood as 'a standing or a status that is bestowed on one human being by another in the context of relationship and social being'. Personhood in this respect is therefore about the morality of accepting and acknowledging the right of the person with dementia to be equal to the person caring for them.

When I reflected on the way I communicated with people living with dementia, I identified with having occasionally used 'malignant social psychology' methods of communication and, on further reflection, was able to acknowledge that I could learn improved ways to communicate through adopting a social model of care and being more holistic in my approach to physiotherapy practice.

The shared recognition of discontent and the process of transformation

Critical reflection for me not only considered self-examination, but also an awareness of others. Mezirow (1997) suggested the process of dialogue with self and others is an essential medium through which transformation is encouraged and developed. Dialogue that emphasises honest and relational communication can be perceived as 'highly personal and self-disclosing' (Carter, 2002, p 82). Writing a reflexive diary was encouraged and promoted throughout the masters course and this acted as a means to support internal or 'self' dialogue and as a reference to monitor how my own presuppositions were affected by the programme. Through engagement with fellow students it became apparent that my feelings of unease regarding my practice were not unique, and that others also began to question their assumptions and feelings about their own practice. Mezirow (2003) suggests that communicative learning refers to understanding the meaning of other people's communication. An awareness of others' assumptions, intentions and qualifications is, he says, an important aspect of communicative learning.

I developed an understanding of the term 'perceptions' through focusing my masters dissertation question on this concept. Perceptions are derived from interpreting our senses and the meaning we place on our knowledge and experiences. Our attitudes and behaviours towards people with certain disorders are therefore influenced by our perceptions of that disorder (Joachim and Acorn, 2000). Mezirow's (2003) explanation of communicative learning involves perceiving and interpreting our senses to inform our epistemological and ontological assumptions.

An interesting outcome of taking a philosophical approach to understanding the world and interpreting meaning from our experiences is that I have realised that my epistemological and ontological assumptions were distorted or, as Kitchenham (2008) put it, less developed. I felt reassured when I discovered that the philosophical and theoretical ideas to underpin my newly found paradigm and my way of engaging with the world were shared with others, and philosophers had developed theories to explain some of my thought processes. This was a significant learning experience and one that, in terms of my masters course, helped to inform my research methodology.

My experience also had a profound impact on my relationships with others in terms of communication and being more receptive and open to differences in opinion. On nearing completion of the course, the discomfiting feelings of guilt and shame resulting from my disorientating dilemma are no longer present. Being exposed to 'critical self-reflection' has enabled me to find confidence in questioning knowledge and reality, and in believing that there are many different ways of perceiving a situation and that we are interpretive beings.

Planning a course of action and provisionally trying out new roles

The next stage in the transformative process was integration of knowledge from masters education into the workplace. Stathopoulos and Harrison (2003) identified potential external barriers to professional development and the enhancing effects of masters-level study. Barriers such as underuse of workforce, frustration, resistance to change and career structure were also noted. It was suggested that skills in critical analysis, research and communication developed through masters-level education helped develop confidence and the adoption of a strategic approach to practice (Stathopoulos and Harrison, 2003).

Masters-level physiotherapy courses have been reported to be 'life changing' and 'career changing' experiences for physiotherapists and shown to improve clinical skills, increase confidence and critical understanding of practice knowledge, and to enhance the ability to learn within, and from, practice (Stathopoulos and Harrison, 2003; Green et al., 2008; Petty et al., 2011). From a personal perspective,

masters education has both hindered and facilitated the transition of evidence-based practice into the workplace. Returning to practice has been fraught with mixed feelings and expectations: on the one hand, being armed with new knowledge has spurred me to implement sound evidence in practice and teach others how they can improve practice; on the other, integrating knowledge into the workplace requires a gentle and subtle approach so as to avoid potential barriers. I feel more confident to deliver lectures and training in order to disseminate knowledge and improve awareness of practice when working with people living with dementia. I feel more able to challenge unhelpful communication and behaviour, while being sensitive to how I am imparting information. I have also gained a promotion, so despite feelings of dissatisfaction and negativity regarding my career development when I started the course, my learning experience has opened doors in my career. It has also provided me with the necessary tools to conduct much-needed research in dementia and ultimately to improve quality of life for those living with dementia.

Mezirow (1997) suggested that transformative learning is rooted in the way we communicate and this was the emphasis in planning my course of action. In keeping with findings from studies evaluating the effect of masters-level education on practising physiotherapists (Stathopoulos and Harrison, 2003; Green et al., 2008; Petty et al., 2011), I have developed improved communication skills, greater confidence and the ability to articulate research evidence to improve evidence-based practice in the workplace. Developing an understanding of rational discourse and involving others in the learning process has heightened my skills in reading others and interpreting the influence of my communication on the responses of others.

Conclusion

The ability to critically reflect has enabled me to deconstruct my taken-for-granted ways, opened my mind to new ways of understanding knowledge and reality, and broadened my appreciation of evidence-based practice and sound clinical reasoning skills in my physiotherapy practice. This process of reflection has heightened my awareness of the potential influence of our preconceptions on our practice. I shared the experiences of some of the participants in Petty et al.'s (2011) study when I became more satisfied with my practice having implemented the knowledge gained from my masters education when working with people living with dementia.

Mezirow's (1991) transformative learning theory and the adoption of an attitude of critical reflection have provided me with a useful framework to resolve my disorientating dilemma of whether I was implementing the best evidence-based practice when working with people living with dementia.

Masters education has been a valuable and insightful experience and one that has not only helped me to improve my practice, but has also facilitated character development and personal growth. The importance of continually reflecting on how information is interpreted and imparted has been my main learning outcome. My greater appreciation of the importance of sensitive and person-centred communication when working with people living with dementia has brought positive feedback and greater job satisfaction. Implementing evidence from good-quality research into practice has empowered me to continue working towards evidence-based physiotherapy practice and to help others to do the same.

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