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Should I intervene or not?

Reflexive learning in Forum Theatre: A peer dialogue on a facilitator’s dilemma.

Helle Merete Nordentoft & Birgitte Ravn Olesen

Forum theatre is a dialogic method with potential to bridge the gap between practice-based and academic learning in higher education by enabling postgraduate students to act out and critically reflect on everyday dilemmas. In previous research, little attention is placed on the crucial role of the facilitator and the implications of her decisions to intervene or not in the Forum Theatre for participants’ reflexive learning. Applying an autoethnographic lens in a co-constructed narrative followed by a peer dialogue, we expose emerging emotional in- and exclusion processes with regard to this dilemma. In our peer dialogue and critical reflection on the narrative we unravel ethical dimensions of the decision to intervene or not. We discuss the delicate balance between othering certain participants and questioning their taken-for-granted knowledge in order to facilitate reflexive learning. As such we provide insights into the complexity and ethical dimensions of facilitating Forum Theatre.

Keywords

Facilitator, forum theatre, critical reflexivity, emotions, autoethnography
Introduction

For the last four years, we have taught a postgraduate course on communication for psychiatric nurses where we facilitate Forum Theatre (FT) as part of their training as clinical specialists. FT is a form of participatory theatre (Boal, 1974) and a dialogic method allowing those taking part to learn by discussing, acting out and critically reflecting on dilemmas the encounter in everyday work situations (Dennison, 2011; Edmiston, 2012; Erel, Reynolds, & Kaptani, 2017). In academic learning contexts, facilitators must balance consideration of participants’ varying conditions and needs while remaining mindful of the learning objectives. In this process, the facilitator navigates between different, and at times contradictory, positions – expert, researcher and coach (Northedge, 2003). When the ambition is to create a multi-voiced space, it also becomes necessary to pay attention to how interactional power dynamics unfold, which voices are heard and what meaning is attributed to them before deciding to intervene or not (Phillips, 2011). However, this ambition is not straight forward and making moment-by-moment decisions about intervening or not can present a dilemma for the facilitator with regard to creating a safe space for reflexive learning. On the one hand, challenging participants’ taken-for-granted understandings can make new voices heard and instigate fruitful discussions, which can lead on to reflexive learning. On the other hand, participants’ who are challenged in their tacit understandings may feel that they are picked on/out, potentially treated unjustly or unfairly. In this regard, we have found, that there can be a tension between adhering to a normative ethical perspective on practice while at the same time insisting on a situated and discursive ethical position. From a normative position, a facilitator’s ambition is to be fair, just and to practise autonomy and democracy. A discursive position on ethics questions that it is always possible to do good in the absolute sense of the word (Christensen, 2016). As is the case with the example above, it depends on the participant’s perspectives in the specific situation whether or not you do good.
In a previous article (author, 2013), we explored how we as facilitators affect knowledge production and learning at a peer-observation workshop in a healthcare setting. Here, we demonstrated how we - despite our ambition of establishing and engaging in a democratic and collaborative learning environment - enacted a methodology based on fixed positions and power relations and excluded certain voices even though we explicitly set out not to do so. Within the action research community, it is suggested that democratic dialogues and knowledge production occur when facilitators “give up being in control and begin listening to what emerges, within themselves and in relation to their various partners” (Phillips & Kristiansen, 2013, p. 267). However, when we relinquished control and decided not to intervene in the peer-observation workshop, underlying power dynamics undermined the principle of mutual learning among equals. In light of these findings, we advocated for more context-sensitive research into the ways in which power relations unfold in collaborative settings. We explored the conditions enabling a facilitator to relinquish control and the consequences of not intervening for participants’ learning. In accordance with these findings, Meyer and Wood emphasize the importance of self-reflection and an awareness of personal biases (Meyer & Wood, 2017).

Previous research on FT is scarce (Dennison, 2011; Edmiston, 2012; Erel et al., 2017; Hansen, 2016) and has yet to investigate the interactional dynamic between facilitator and participants and how it affects learning. Moreover, Kumrai et al suggest the need for more research on how decisions are made in the final selection and re-enactment of a story in FT (Kumrai, Chauhan, & Hoy, 2011, p.527). In this article, we seek to address this gap in the research by critically reflecting on the ways in which facilitators’ navigation and decisions to intervene or not in the Forum Theatre affects participants’ reflexive learning.

We begin by presenting our theoretical understanding of critical reflexivity and learning followed by an introduction to FT and reflexive learning in light of previous research on FT in the fields of social services and healthcare. In the methodology section, we first describe how we have staged the FT process in the postgraduate communication course in a psychiatric setting. Then we outline our autoethnography-
inspired approach, in which we critically reflect in a peer dialogue on a co-constructed narrative on the ethical dilemmas one of us experienced as a facilitator when working with FT.

**Critical reflexivity and learning**

Educational researchers suggest that students can have a hard time adopting a critical-reflexive stance – and that they are often more descriptive than reflexive in their reflections (Meyer & Wood, 2017; Ryan, 2013; Tuttici, Ryan, Coyer, & Lewis, 2017). Coward even suggests that a certain “reflection fatigue” has entered higher education (Coward, 2011, p. 883). According to Coward, the many structured reflection models developed from Schön’s or Boud’s theories on reflection (Boud & Molloy, 2013; Schön, 1994) obstruct a critical reflexivity, which is characterized by an attention to contextual complexity, power relations, and inherent dilemmas in incidents from practice (Bassot, 2014; Cunliffe, 2002; Cunliffe & Easterby-Smith, 2004; Phillips, Kristiansen, Vehviläinen, & Gunnarsson, 2013). From a social constructionist perspective, FT can provide both facilitators and participants with critical-reflexive and ethical insights into taken for granted ways of being in the world by inviting discussions on the reflexivity of professionals’ thoughts, actions and the institutional context.

Inspired by Phillips (2011) and Phillips et al. (2013), the theoretical foundation for our work with critical reflexivity combines Bakhtin and Foucault. A Bakhtian approach allows for detection of how meaning is created contextually and dialogically in the struggle between difference and unity across multiple voices. A voice in this understanding is not the same as the physical organ or meaning of an utterance and it is not associated with a single person. Voices can be statements, understandings and values uttered and negotiated in a dialogue (Bakhtin, 1981). Each person expresses multiple and varied voices when engaging in dialogue with another person, because meaning, according to Bakhtin, is produced dialogically in the tension between different and often contradictory and competing voices. For instance, a nurse can state that she wants to listen to the patient’s experiences and at the same time expect the patient to respect her professional knowledge. Her utterance involves a tension between a
democratic discourse and an expert knowledge discourse. Tensions and differences between voices are seeds of change. As such, when participants in FT negotiate, mediate and try to understand tensions between different voices, this process is a prerequisite for learning and development.

A Foucauldian understanding provides a discursive and situated ethical perspective on the ways in which power as a basic condition of social interaction affect all meaning-making processes. This approach allows us to highlight the inexorable operation of power/knowledge in discourses and how they affect the construction of knowledge and subjectivities in particular ways that may marginalize or exclude other ways of being, knowing and doing (Foucault, 1980). In this understanding, identity and meaning are co-produced in social interactions, and differences are invoked and produced through relations to "the Other" (Bakhtin, 1981; Stewart, Zedicker, & Black, 2004). Invoking difference can be productive, but it becomes a problem when othering rests on a normative evaluation of others in which individual characteristics and/or actions are classified as right or wrong. Therefore, the examination of the mechanisms of in- and exclusion in tensional moments can potentially minimize othering and, therefore further the inclusion of marginalized voices (author, 2018). In the next paragraph, we explain the ways in which we draw on this line of thinking in reflexive learning processes.

Forum Theatre and reflexive learning

Many professionals attend postgraduate communication courses in which they learn how to apply evidence-based normative communication models in practice (Peräkylä & Vehviläinen, 2003, p. 728). These models offer schematized approaches to how social- and healthcare professionals can communicate in meetings with clients and their relatives. However, they do not support professionals in understanding the complexity of situated interactions where unexpected emotions often play a significant role and have a major impact on how clients and their relatives understand what the professional is saying. As a professional, you are expected to act on the fly on unpredictable, spontaneous and complex interactions with clients and their relatives, as well as with colleagues. What
constitutes good communication is in constant flux, dependent on the local context. Furthermore, evaluating what and/or how it is relevant to communicate requires the ability to grasp what is at stake in a specific situation – just as is the case with facilitators’ practice we focus on in this article. In other words, communication between people is always embedded in and shaped by the cultural context. In this regard, critical reflection among peers in FT on difficult situations can generate situational and context-specific knowledge (Deeny, Johnson, Boore, Leyden, & McCaughan, 2001; author, 2013, 2018) and enable them to “take greater control over sharing strategies for dealing with challenging and complex work situations” (Kumrai et al., 2011, p. 518; Sappa & Barabasch, 2019). Bolton (2004) asserts that a narrative structure can assist memory and develop a deeper understanding. So when participants study and work with their own experiences, they are likely to remember them better than when exposed to academic approaches to learning. Kumrai et al, therefore, contend that FT can bridge the gap between practice-based and academic-based learning in higher education and complement cognitive and rational approaches to learning and reflection. Moreover, a dialogic approach can draw attention to how power dynamics of oppression and discrimination arise in practice and thereby qualify development of more democratic and anti-oppressive approaches to communication within the workplace. Still, several researchers have suggested that FT can also lead to individualization and/or quick-fix solutions to concrete problems rather than supporting participants’ critical reflection on potential relationships between these problems and the structures they are embedded in (Erel et al., 2017). In this regard, Erel (2017) and author (in press) emphasize that the FT facilitator plays a crucial role in engaging participants in a deeper and critically reflexive analysis of what is going on in specific situations; for instance, uneven power dynamics and/or social inequality on a political/economic level. If such reflection does not occur, contrary to intent there is a risk that participants falls victim to normative assumptions about how one can and should behave as a professional.
Methodology

Forum Theatre in a psychiatric setting

This article builds on data from a research project exploring how FT can enhance a postgraduate practice-based learning context. The project had two inter-related objectives.

1. First, we investigated participants’ learning processes in FT, including the development and impact of a critical reflexive approach on everyday practices.
2. Second, as is the case in this article, we focused on the position and reflexivity of the facilitator and the ways in which her navigation in the FT affected participants’ learning.

As external researchers, we planned communication workshops in close cooperation with the two directors of the postgraduate programme in psychiatric nursing. During this planning process, we adapted FT to fit the programme’s formal requirement that participants develop a critical-reflexive perspective, considering how institutional, professional and personal (including bodily/emotional) responses influence their communication and actions. Inspired by Kumrai et al (2011), we used a ‘live’ research methodology in which we alternated between physical and emotional involvement and oral discussions. This interactive modus gave the participants an opportunity to reflect on their experiences before, during and after the workshop.

The FT workshop step by step

The one-day workshop had 35 participants, mostly women between mid-twenties and fifties, from psychiatric units spanning the greater Copenhagen area. In the morning, we introduced a theoretical framework for working with FT and gave participants a hand-out presenting the central concepts. The participants were split into two workshop groups, where each facilitator outlined our ethical considerations regarding the sharing of real-world situations and how information disclosed should be treated in full confidence. Despite occurring in a professional context, the facilitators acknowledged how
personal it could be for participants to share an incident where something went wrong. They, moreover, emphasized that FT is not about evaluating good or bad performances. Linking to our theoretical framework for the workshops (Bakhtin & Foucault, as detailed earlier in this article), the facilitators addressed how different situations call for different reflections and actions – and how different professionals will act differently.

Groups of five participants was formed in each workshop. In each group, all members first described a challenging situation from their own professional practice and then they selected either the most familiar or the most challenging situation. Next, the participant who originally shared (and experienced) the situation prepared her colleagues to stage it for the rest of the workshop group. To ensure joint ownership of the scenario, the facilitator emphasized that the chosen situations now belonged to the whole group. Gathering in the workshop, all groups briefly presented their scenario, while the facilitator wrote keywords on a whiteboard. Finally, there was a democratic election where it was decided, which scenario the participants wanted to work with. The chosen scenario was staged once without interruption from the audience. The second time it was staged, the facilitator invited members of the audience to replace the protagonist and enact their suggestions. It could be suggestions for alterations in verbal or non-verbal communication, or perhaps (as is the case in the scenario in this article) involve changes to the physical environment. At the end of the session, the facilitator’s written notes on participants’ suggestions were used as the basis for a critical-reflexive discussion of the events depicted in the FT.

An autoethnographic lens on Forum Theatre

The scenario we work with in this article is one out of 24 scenarios we have collected from the postgraduate course in communication for psychiatric nurses. A facilitated the workshop and it is in many respects typical because it portrays an emotionally engaged discussion of principles for practice, leading to a series of broader discussions about inherent dilemmas of how to act as a psychiatric nurse.
However, it was unusual in the sense that it moved A more than normally. She experienced what Cunliffe (2004) refers to as an emotional “struckness” as well as doubts regarding the decisions she had made in her facilitation. Therefore, she was eager to discuss the potential effects of her decisions on participants’ learning with B.

Using an autoethnographic lens (Holman Jones, Adams, & Ellis, 2013), we examine the incident in a co-constructed narrative in which we reflect on emotional, moral and ethical dimensions of the interactions between the facilitator - i.e. A and the participants. As such, there is a clear parallel between the critical reflexive exercise we invite the participants to undertake in the FT workshops, and the aim of the co-constructed narrative we present in this article.

Inspired by Emerald and Carpenter, we interrogate the possibilities and pitfalls and examine “the emotions, uncertainties, and doubts” that A experienced (Emerald & Carpenter, 2015) and revisit her discomfort when working with this particular scenario. We use these uncertainties and emotions as a method of inquiry which means that we look at emotions as data and not mere “tales and anecdotes” about emotionally challenging incidents (Coffey, 1999, p. 90). In this regard, Heen asserts that emotions can “convey quite accurate information about the outer world” (Heen, 2005, p. 2070).

It may be challenging to give meaning to emotionally sensed knowledge (Hubbard et al., 2001) with a peer (Hammersley-Fletcher & Orsmond, 2005; McLeod & Steinert, 2009; author, 2012). However, it can also be rewarding because, according to (Davies et al., 2004), we contribute to meaning-making processes as we deconstruct them. In this regard, Cunliffe points out that inquiry into emotional incidents can illuminate the tacit and taken-for-granted aspects of practices emerging from the experience itself. By reflexively examining moments where we are “struck”, we can make sense of our experience (Cunliffe, 2002). Moreover, this investigation can lead to the creation of a practical, embodied and situated knowledge. In summary, our experiences and emotions function as a sort of
amplifier, “privileging the emotional as well as the intellectual components of understanding, urging a rethink of the relation between knowledge and emotion” (Holland, 2007, p. 748).

**Critical reflexive peer dialogue on a co-constructed narrative**

In the following, we zoom in on two episodes in the scenario in which A was unsure of her decision to intervene or not. In the first episode, she intervened and took charge of the situation and in the second episode, she did the opposite - i.e. she relinquished control and let the enactment of the scenario unfold without intervening. In our peer dialogues, presented below, we strive to uncover the nature of her emotional reaction, the rationale for and ethical implications of these decisions, and their impact on participants’ learning.

**Episode 1: A different seating arrangement?**

After the work with FT in our respective workshops, we meet over a cup of coffee to discuss the events of the day. A tells how two episodes in one particular scenario had stayed with her and begins to describe the first:

The scenario is set on a closed ward, in a small room shaped in such a way that the patient has to pass closely by staff to leave the room. Three nurses are playing the parts: One plays the role of a male patient, one a female physician and the last plays the patient’s female contact nurse. The patient had been sentenced to attend and be treated at the hospital daily. The previous day, the police had brought him to the ward due to a violent assault. He has been sentenced to stay at the ward until a physician discharges him, but the patient wants to leave: “I don’t want to be here; you have no right to keep me here”. He seems agitated and becomes angry when the physician tells him “That is for me to decide” and “For now, you just keep taking your medicine”. The contact nurse supports the physician and says that “a discharge is not on the table right now”. The same arguments are repeated over and over again. Finally, the patient gets angry and tries to leave the room. However, he is unable to do so without forcing
his way past either the physician or the contact nurse. The scenario ends with the patient spitting in the nurse’s face as he passes her on his way out. The scenario seems to deeply affect everybody in the room. Afterwards, some of the participants exclaim “that’s just out of order” or “how revolting”.

In the second enactment of the scenario I invite everybody to raise their hand with suggestions as to how the nurse could have acted differently. I haven’t even finished my sentence before one of the participants raises her hand and suggests that it is the patient and not the staff who should be sitting closest to the door. This suggestion makes several participants voice excessive opposition. In a forceful and rather loud manner, they make comments like: “It’s unrealistic” or “That is reckless and puts us, the staff, in danger”. However, there is also support: “it is obvious that this patient gets violent because he is not only locked up on the closed ward, but forced into the situation where they discuss his predicament”.

For some time, I can’t keep order. People are all talking at once. I sense an almost aggressive atmosphere where the participants are not listening to each other’s opinions. Instead, they are angry and act defensively – perhaps because they sense a threat to their core values. For a majority of the participants, it seems impossible to accept any suggestion of an alternative seating arrangement. I become bewildered and affected by their very insistent voices and marked disagreement. I notice my heart pounding. I feel uncomfortable about not knowing what to do. From their practical experience, several participants argue that “it would be completely unrealistic for staff members to expose themselves to the danger of being cornered if the patient becomes violent”. One of the participants points out that “it would also be unethical to change the seating arrangement because it might lead to a situation much worse than being spat in the face. Consequently, both patient and staff could end up in a worse situation than before”.
I try to list the pros and cons of changing the seating arrangement on the whiteboard. The atmosphere in the room is intense. I have to do something! I hold my breath and hear myself suggest that the participant who proposed the change should try it out despite the arguments against it.

**A messy situation**

A: I am concerned about this emotionally loaded situation because it seems at odds with our good intentions for the FT workshops; we want to create a space where participants can think critically and innovatively about challenging professional situations. As Kumrai et al say, FT involves the capacity to think beyond immediate experience and accept diversity and different opinions whilst retaining a sense of self (Kumrai et al., 2011, p. 521). Instead, I end up with an extremely agitated group and I hear myself interrupt their discussion and take charge of events. I don’t know where that came from. I am still not sure what happened when I suggested trying out a different seating arrangement – or what they got out of it. I wonder if I should not have intervened and taken charge of the situation. What do you think?

B: I can identify with your concern! As a facilitator you constantly have to make these momentous decisions and afterwards you wonder what actually happened. In my opinion, the alternative seating arrangement illustrates how you had to balance between a patient-centred discourse focusing on the patient’s needs and a risk discourse focusing on the staff’s safety. Despite the arguments against, you decided to shut down the risk discourse in favour of the patient-centred discourse. By making this decision and going against some participants’ emotional, ethical and practical concerns, you exposed yourself and risked losing your credibility and perhaps also the trust you had built up among the participants. To me it seems to be a paradoxical situation in which you appear to be torn between your ambition to practice a critical pedagogy that purports to acknowledge the place of emotion and to encourage reflection on it, and at the same time you yourself become surprised and “struck” at the appearance of the strong emotional reactions from the participants. How did you experience the reactions in the group when you suggested trying out the different seating arrangement?
A: Good question! The truth is that I do not know. Thinking about it, the participants did not all react in the same manner. The two participants who most persistently and vocally opposed an alternative seating arrangement seemed to withdraw from the rest of the group. They sat with their arms crossed and did not seem inclined to join in. Maybe they felt that I ignored their position because I chose to go against their suggestion - even after they had expressed it so emotionally.

B: You chose to oppose a local truth on psychiatric wards where mentally ill people are conceptualized as a perceived “danger” or “threat” (Callaghan & Grundy, 2018; Lupton, 2013), which the professionals have to relate to in their everyday practice. I believe they were surprised, and maybe angry. But you had to make a decision. The question is if the two participants who withdrew felt that the opinions they had expressed were excluded as irrelevant. As post-structuralist researchers, we assume that identity and meaning are co-produced in social interactions, and that differences are therefore invoked and produced through relations to “the Other” (Bakhtin, 1981; Stewart et al., 2004). However, if we invoke difference on a normative evaluation in which individual characteristics and/or actions are classified as right or wrong, we may generate strong emotional reactions. Who would voluntarily accept being positioned as “the different other” and “the inappropriate other”? (author 2013b).

A: I think I know what you are alluding to. As Jaworski and Coupland (Jaworski & Coupland, 2005) suggest the primary instrument for the construction of a person’s identity is the invoking of difference in which you objectify, stereotype, naturalize or essentialize certain subjects or groups of subjects. Maybe the two participants felt that I made them the “different other” (author, 2013b) and that’s why their response was emotionally loaded?

B: I think critical and collective reflections on power/knowledge dynamics are crucial in preventing participants from experiencing being othered as “the different other” - considering how working with alternative actions creates situational and contextual knowledge about practice. Just like we do now when we reflect on the scenario after it has been played out.
Balancing on an ethical tightrope

A: I agree! It is a challenge to be critically reflexive as an FT facilitator and go along with the ideals in a relational study. Meyer & Wood, for instance, describe how a facilitator must allow herself to express her critical opinions to participants throughout the process (Meyer & Wood, 2017, p. 162). But this implies that you as a facilitator have the capacity to be critically reflexive during the enactment of the scenario – which is not always the case. Furthermore, despite FT’s ideals of openness, the relationship between facilitator and participants (and the relationships among participants) will also be imbued with power.

B: I agree. Too often, ethics become a question of different approaches. When Kumrai et al., for instance, describe how they strive to enable all voices to be heard in order to minimise marginalisation and essentialism (Kumrai et al., 2011, p. 519). They seem to refer to traditional and normative standards for “ethical qualitative research” (Denzin & Lincoln, 2005) where the individual’s rights are primary. Foucault and other post-structuralists would say that when we do not conceive “power” as something one can possess or exercise over ‘the other’, but as a basic condition in social interaction that affects sense-making processes, then we do not see the facilitator as unequivocally more powerful - and thereby more responsible - than the participants. Moreover, “relationships of power are changeable relations, i.e., “they can modify themselves, they are not given once and for all” (Fornet-Betancourt, Becker, Gomez-müller, & Gauthier, 1987, p. 183).

A: Are you alluding to how, in a Foucauldian perspective, power relations are seen in a dynamic intersection between social position, space and subjective positioning?

B: Yes I am – and this perspective implies that when we, as facilitators, strive to create a multi-voiced space, it is an ethical imperative that we are conscious of interactional power dynamics - which voices are heard and what meaning is attributed to them (Phillips, 2011). I hear that you work with two
different understandings of what it means to be ethical: A normative understanding in which you want to act fairly and justly and respect participants’ autonomy in the enactment of the FT. At the same time, you adhere to a post-structuralist understanding of ethics in which you cannot always be just because power is omnipresent in all interactions. The latter represents an understanding of ethics in which your ethical obligation is to critically reflect on what is at play with regard to power dynamics and emotions in specific interactions. Just as we are doing right now (Christensen, 2016; Phillips, Kristiansen, Vehviläinen et al., 2013). What if the (ethical) question at stake here is not whether or not you should have intervened but rather the place of emotional responses in decision-making more broadly – both with regard to the specific incident which was played out in the FT and with regard to your response to it as a facilitator? This change in perspective would alter the question from whether or not you should have intervened – to why you did so in the first place – and how the interplay of power and emotion contributed to your decision making.

You describe a tension between staff safety and the patient’s feeling of being trapped. You allowed the two voices to be heard and confront each other and, importantly, they were both written on the whiteboard. I am not the one to judge whether or not you othered those two participants or if your decisions can be considered ethically problematic. However, I get the feeling that your suggestion to let the patient sit next to the door and favour the patient-centred discourse - perhaps silenced certain voices and made some of the participants feel like “the different other”. Nevertheless, it allowed new and different perspectives on the situation. I wonder what the participants said about the scenario during the subsequent dialogue? What do you think they learned?

A: As far as I remember, several of the participants said that they did not know which seating arrangement they preferred. It made a big impression on them that the participant who had played the patient revealed how she had a mental, physical experience of “being in the patient’s shoes”. The different seating arrangement made a big difference to her. She felt less trapped in the room and could
better concentrate on what the others said. Apparently, her statement had a significant impact on several of the participants – maybe because her remarks suggest that it can also put staff at risk if the patient feels unsafe and agitated. Therefore it can – in fact - be safer to let the patient sit closer to the door. As such, I think that the enactment of the scenario and ensuing discussion gave the participants a broader perspective on risks and their causes when working with psychiatric patients. My decision to intervene seemed to make them recognize that and see that interaction with patients and colleagues is not only verbal. The physical surroundings and the institutional context also have a huge impact. So, what did they learn? I think our critical-reflexive discussion of the significance of different seating arrangements showed them how even the placement of furniture can be a powerful gesture that impacts on what we think, say and do. Importantly, talking to you makes me realize that we could have discussed the dynamics between emotion and decision-making. It would have been important points of learning not only for these student practitioners but also for me – perhaps in a follow up session. Right now, follow-up sessions do not take place, but it could be worth considering in our future work with FT.

**Episode 2: Talking to or with the patient?**

After the discussion of the alternative seating arrangement, the enactment of the scenario continues. Hands are raised. A lot of the participants get the chance to sit in the contact nurse’s chair; some more than once. After a while, the two participants who seemed to withdraw their engagement after my “seating decision” also make suggestions. Several of those playing the contact nurse try to explain to the patient “you have to understand that you can’t be discharged right after a violent assault” or make reconciliatory statements such as “I do understand, but...”. After a while, the nurses succeed in calming the patient down. I let the scenario progress without intervening, despite some misgivings. While it is good that the participants make their own suggestions, I am worried that they seemingly conclude that supportive and friendly communication is sufficient to keep both patient and physician content. After contemplating whether or not to intervene, I limit my role to taking notes, writing participants’
suggestions on the whiteboard and facilitating that they in turn take on the role as contact nurse. Suddenly, a participant suggests that, instead of talking to the patient, the contact nurse should talk with him. I write this suggestion on the whiteboard and the new contact nurse now asks the patient questions like “What happened yesterday?” and “What is the most difficult thing for you right now?” Everybody seems to notice the difference it makes. Until now, the ‘patient’ has repeated the same few sentences. Suddenly, he elaborates on them and reveals why he thinks it is unfair that he has been brought to the hospital. “The most difficult thing”, he says, “is that I don’t know my rights. I feel like a child in relation to you. You can decide everything; I can’t decide anything”. Next, participants playing the contact nurse explore options for accommodating the patient’s needs other than being discharged — for instance they say: “I can join you in the garden for a cigarette”. This shift to focusing on the patient’s perspective makes a difference to the relationship between the contact nurse and the patient. A bit later, one of the participants goes so far as to align herself with the patient’s position, asking the physician “Can you tell us what it would take for the patient to be discharged?” The physician rejects the request from the contact nurse and says: “That is not relevant right now”. However, this question makes the patient see the nurse as a potential ally. Together, they (the patient and the nurse) insist that the physician must clarify the conditions for discharge, suggesting another meeting to assess how these conditions can be met. Several participants align with this strategy when playing the contact nurse. After approximately 45 minutes no new suggestions are raised and I choose to stop the play. I sense that both patient, physician and contact nurse seem more relaxed, even though the patient’s situation remains unresolved.

*Normative communication skills – or critical awareness?*

A: After the first episode, I guess I might have been a bit shell-shocked. Anyhow, as you can hear, I chose not to intervene in this second episode. So, my question now is the opposite of my first question: Should I have intervened? Or was it the right decision not to do so?
B: I think it sounds like a good decision not to intervene, because the participants found new solutions by themselves. I would guess it makes a stronger impression if the ideas in the FT come from the participants.

A: I agree, but I almost had to sit on my hands not to intervene. It felt like an eternity when the participants took turns playing the role of contact nurse in ways that were in accordance with normative guidelines for good communication. From a participatory point of view, it is good that they come up with suggestions that seem to work well in the situation by themselves. Still, I had this nagging concern that their apparent success employing a communicative strategy based on affirmation and reassurance could lead them to conclude that appreciative and active listening – i.e. normative ideals for good communication – can in itself resolve problems.

B: I understand! It might make them conclude that such problems do not arise when nurses have the right communication skills. Moreover, this conclusion potentially leads to victim blaming because the problem can be linked to the nurse who originally experienced the situation. A conclusion like “she could have communicated better” ignores the institutional context and how it co-constitutes the nurse’s communication.

A: Exactly. My reluctance as “the university professor” to challenge the dominant and normative discourse about “good communication” potentially reinforces it, potentially leading the participants to see it as an indisputable truth.

B: Yes, and in this regard Kumrai et al, (2011) refers to Paulo Freire who says that “critical perspectives should be seen as an achievement rather than a natural outcome of participants’ experiences” (Kumrai et al, 2011, p. 521). Meyer & Wood support this view when they suggest that “…it is possible to practice reflection without being critical or changing anything” (Meyer & Wood, 2017, p. 162).
A: Yes, during the shared reflection, the participant who chose to talk with rather than to the patient insisted that “the patient needs to feel heard”. Her actions seem to honour a more patient-centred discourse by attempting to meet the patient half-way. The nurse’s remark can also be seen as a strategy to bring an emotional FT scenario to a successful ending. Therefore, I still worry that - contrary to the first episode - my non-intervention shaped participants’ learning. However, her actions only partly challenge the original understanding of the situation – i.e. that the problem belongs to the patient and his actions, rather than those of the staff. In fact, in her formulation she does not appear to respect the patient’s rights when she says “the patient needs to feel heard”. If she had said:” the patient needs to be heard”, I would feel more certain that she insisted on the patient’s voice to be heard. Such an understanding could lead to broader, multi-voiced understandings of the situation.

B: What I find interesting here is that something actually happens! One of the participants introduces a new voice when she sides with the patient. She goes as far as to align herself with the patient when she asks the physician to clarify the terms for the patient’s discharge and how to evaluate if they are met. This request puts her in opposition to the physician.

A: Yes, it led to a major discussion after the scenario about institutional norms and expectations regarding what constitutes a good and loyal colleague. Some participants rejected this patient-centred approach, stating that it would lead to exclusion from the ward’s collegial community. My intervention seemed to make participants’ transfer from a medical discourse (as described in the first scenario where the problem was the patient who spat at the nurse) to a more patient-centred discourse (where the nurse practiced active listening). Finally, we saw the evolvement of a fully patient-centred discourse in which the patient was supported - even if it placed the nurse in opposition to the physician.

_Multi-voiced dialogues in Forum Theatre_
B: I think the events you describe show how FT opens up for a diverse array of interpretations and actions. It gives professionals an opportunity to look at and “play” with their practice in ways that highlight tensions, raise questions and initiate shared reflection. However, there is also a risk of individualizing or over-simplifying structural problems, leading to quick-fix solutions (Erel et al, 2017; author, in press). The discussion about the seating arrangement can be seen as an example of such a problem. It could illustrate a matter of staff safety; however, the same incident can also indicate power asymmetries and how various discourses are at play in a psychiatric context, where the wellbeing of staff is always considered more important than that of patients. Participants’ reactions clearly indicate that showing solidarity with the patient rather than colleagues isn’t straightforward because they illuminate strong tension between two legitimate considerations.

So – I do understand, that you wonder if you have challenged the participants enough. If dominant discourses become too manifest in the enactment of the scenario, there is a risk that acting correctly becomes the primary focus. As is the case in both the first and second episodes, the facilitator is called on to make decisions that uncover subordinate discourses and reveal how power-infused all our actions are.

A: Thank you for having this discussion. From our talk, I have learned that my spontaneous decisions as facilitator seemed relevant in the process of developing a critical-reflexive perspective on the students’ practice. The scenario we enacted was immensely complex and I think we succeeded in unravelling tensions between normative ideals and situated interactions, both during the enactment and in the subsequent shared reflection. I am left with a reason to hope that the participants learnt that dialogic meaningmaking is an inherently complex, tension-ridden entity requiring a constant awareness of how both professional and personal (including bodily/emotional) responses influence professional communication and actions. What has really struck me from our conversation is how subtle but also dominating both my own and the students emotions seem to be in the decision-making processes we
work with in the FT. So really, my initial question about whether or not to intervene could be transformed into a question of why I intervened at all and how emotions were at play in my decision-making. Next time we talk after a FT – let’s focus on that!

Conclusion

In FT, practitioners can act out, discuss and gain insight into situated dilemmas from their everyday practice. As such, FT can combine practice-based and academic learning in higher education by integrating cognitive and rational approaches to learning and reflection. However, the spontaneous and innovative nature of FT makes it impossible to predict what will happen. As a facilitator, you must have a constant and critical awareness of the complex forces at play; however, despite our best efforts, these forces often go unnoticed (Bishop & Shepherd, 2011). Social relations, processes of recognition or rejection, institutional rules and regulations and the messy nature of everyday life all co-produce the conditions for learning. Learning is a dynamic process in which emotions, power relations and decision-making are closely intertwined. In this article, we have investigated how a facilitator’s navigation appears to affect participants’ learning. In a peer dialogue on co-constructed autoethnographic narrative, we critically reflect on the implications of her choices for the evolvement of the FT. In both instances, ethical tensions emerges between the normative ideal of doing good and a discursive practice in which this ideal is constantly challenged by emerging in- and exclusion processes whereby some participants potentially become othered. When the facilitator intervened, participants were confronted with their tacit and taken-for-granted assumptions and priorities. In this regard, a we recover a strong tension between two legitimate considerations in the play. On the other side, the facilitator’s (non-)intervention appeared to encourage a multi-voiced dialogue wherein a patient-centred discourse became more prominent. Lastly, the peer dialogue facilitates a different and
transformative understanding of the situation. The initial question about whether or not to intervene is transformed into a question of why the facilitator considered to intervene at all – in other words, how we can approach the interplay between emotions and decision making in professional practice. In conclusion, we assert that peer dialogue about emotionally charged incidents can highlight the complexity and tacit taken-for-granted aspects of both facilitator’s and practitioners’ practices.

References


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