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Two-eyed seeing, arts-based reflection and collaboration: Reflexivity tools for nursing practitioners working across cultures

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Abstract: This paper explores how the use of reflexivity, an approach to knowledge construction and understanding, provided a structural framework for a doctoral student of psychology as she conducted a literature review and worked as a registered nurse in clinical practice. Her reflexive practice allowed for the exploration of perspectives, biases, values and knowledge system and therefore it added rigour, credibility and trustworthiness to both her literature review and clinical work. Although Janet is not a psychotherapist, her reflexive practice shaped the relationships she developed and influenced the care she provided to people living with diabetic foot ulcers because her therapeutic and community involvement overlapped. Janet's reflexive practice helped her move beyond the delivery of physical wound care towards more inclusive and expansive relationships with individuals, communities, doctors, psychologists, and family members. As these collaborative and inclusive relationships developed, questions about struggles and socio-cultural knowing influenced her understandings and pushed at what she imagined holistic and culturally relevant care might involve. Because her clinical work was geographically located within Aboriginal communities, her reflexive practice was also informed by the principles of Two-Eyed Seeing. Writing, journaling, listening, conversations and creating 'art-as-event' are the strategies which serve as a resource for this paper. In addition, it is important to note this reflexive writing is collaborative and multi-disciplined (nursing, psychology, and education). Our collaboration resulted in opportunities to understand, challenge and value other perspectives born and experienced on landscapes unfamiliar to us as individuals, professionals and women working in communities.

Keywords: Reflexive practice, two-eyed seeing, diabetic foot ulcers, art-as-event, culture, diversity, collaboration

This paper demonstrates how a reflexive practice (Finlay, 2012), including the use of the Two-Eyed Seeing guiding principles (Bartlett et al., 2012) and art-as-event (Greene, 2001), shaped a doctoral literature review. Moreover, working alongside a collaborative writing partner from a discipline other than nursing (namely, education) demonstrates how reflexive practice created additional opportunities to challenge assumptions, pay attention and deconstruct

privilege as we reflected on work done alongside community members living with diabetic foot ulcers.

Within this paper, there are two temporal layers of reflexive practice: The first reflexive layer occurred when Janet was compiling the literature review and working in-community with persons living with diabetic foot ulcers. This was the case because a reflexive practice was a routine part of Janet's clinical work. It was also a required element of her doctoral

studies. The second opportunity to engage in a reflexive practice occurred when Janet shared this work with Sandra, and they began collaborating through reflexive conversations and writing. Sandra introduced literature, questioned, learned and helped shape the paper¹. Thinking about the stories and memories Janet compiled and using one or more of the scaffolds (Two-Eyed Seeing, art-as-event and collaboration) we reflected, explored, and deconstructed a literature review and an in-community nursing practice. This led to opportunities to imagine forward looking, culturally relevant in-community nursing practices and a greater understanding of the power of a reflexive practice.

While neither of us are psychotherapists, we believe the stories we are sharing here are relevant to all forms of therapeutic work and clinical practice. We hope the stories of trauma (physical and psychological) will resonate with readers. The challenges we document concerning work in cross-cultural contexts, specifically with Aboriginal peoples, are mirrored in work across the world and we think might be of special interest to our European colleagues who support anti-oppressive practices. We also seek to showcase the Two-Eyed Seeing guiding principles that shaped this qualitative research which we hope will intrigue and stimulate further creativity in academic endeavours.

Story Number One: Collaboration

I (Janet) am a team member of a community based wound care clinic. I often sit on a rolling stool, energized and prepared. My legs tucked alongside (potential energy, at the ready) waiting for people to position themselves on prepared chairs or stretchers. I push hard with my feet releasing the energy and propel myself to the foot of each stretcher to assess wounds on the feet or remaining feet of persons living with diabetes. This unsettles me because I am keenly aware that diabetes related foot ulcerations are preventable and therefore amputations are as well (Diabetes Canada, 2018). I proceed to debride foot calluses and provide wound care as required. As I provide care, the time and space between is experienced as safe and stories emerge. I hear descriptions of complex pain as it relates to spiritual and emotional well-being and stories of changes to employment status. I am frustrated because the limited 'clinical-minutes-per-person' focus is primarily on physical wound care interventions centered on treatment and management and not preventative, culturally relevant care.

¹ As the reader you will note changes in pronoun use, I and we. This is the result of the temporality of the reflexive practice and our collaboration.

² The stories in this paper are compilations of people I worked with and served throughout my career; they are composite identities (Brookfield, 2015).

³ Aboriginal peoples - include persons of Indian, Inuit or Métis descent regardless of where they reside and whether or not their names appear on an official register. The term "Aboriginal" fails to reflect the distinctions among

Later in the day as I reflect in my journal, I wonder:

Is there a lack of awareness because people cannot describe preventative foot care and footwear choices that would protect and or save remaining feet? Alternatively, I wonder are we as health care professionals delivering effective, culturally relevant, community, and individual specific foot care and footwear education (J. L. Kuhnke, *personal communication*, August 2012).²

Operationalizing Reflexivity

Reflexivity brings credibility, rigour, trustworthiness and validity to qualitative research (Finlay, 2012; Jootun, Mcghee, & Marland, 2009; Lincoln & Guba, 1985; McCabe & Holmes, 2009). I utilized a reflexive practice as a doctoral student in psychology reviewing literature and while working as a registered nurse alongside Aboriginal³ people in-community. While the requirement to engage in a reflexive practice was an assigned element of my doctoral studies, it was also a practice I previously and routinely utilized and valued.

When it comes to practice, the process of engaging in reflexivity is perilous, full of muddy ambiguity and multiple trials. To what extent should researchers give a methodological account of their experiences? How much personal detail can be disclosed and what forms can it take?... In some ways, embarking on reflexivity is akin to entering uncertain terrain where solid ground can all too easily give way to swamp and mire....Researchers have to negotiate the 'swamp' of interminable self analysis and self disclosure. (Finlay, 2002a, p. 212)

Reflexivity requires "subjective self awareness" and an understanding of the "lived experience that resides in the space between subject and object" (Finlay, 2002b, p. 533). Reflexivity can include but is not limited to writing, poetry (Finlay, 2012), reading, and art. Greene (2001) described art-as-event as listening, dialogue and "imagination that draws [me] on, that enables [me] to make new connections among parts of... [my] experience" (Greene, 1995, p. 28).

Two-Eyed Seeing reminded me to attend to inter-relatedness, co-existence and community spirit (Institute for Integrative Science & Health, 2017). These principles were developed (2004) by Mi'kmaq Elders, Doctors, Murdena and Albert Marshall.

First Nations, Inuit and Métis peoples, who have their own histories, cultures and languages, so an attempt has been made to limit use of the term in this Policy to instances where a global term is appropriate. Indian peoples commonly identify themselves by distinct nation names such as Mi'kmaq, Dene or Haida, and as First Nations. In the international context, the term comparable to Aboriginal peoples is Indigenous peoples (Government of Canada, 2014, para. 18). Following the lead of Battiste (2013) the term Aboriginal is used throughout this paper.

Art-as-Event (i.e., reflexive journaling, paintings and poetry) engaged me as a practicing artist because it allowed me to use both my art and journaling together in an integrated way. I know “art as central to the life and growth of a culture; and both see the human significance of the arts deriving from reflective personal engagements with the visual arts, [and] works of literature” (Greene, 2007, p. 1). Art can “nudge us out of somnolence and move us somehow to choose to act, to engage in a beginning” (p. 121). Finley and Knowles (1995) describe notions of “researcher as artist” and “artist as researcher” as part of the aesthetic and artistic research expression (p. 110). Rae and Green (2016) purport space, time and working relationship gives “free rein to deep thinking and a synthesis of emergent understanding” as one grows (p.1544). I was keen to grow and challenge my “blind-spots and taken-for-granted assumptions” (Finlay, 2012, p. 7). Reflexivity is most effective when the researcher is open and willing to be inquisitive and uncomfortable throughout the process.

Collaboration with Sandra, who is positioned within the educational discipline occasioned moments that resulted in “bringing together aspects of the subject that previously did not appear to be related” (Riddell, 2018).

Positioning of Self

A reflexive practice keeps me mindful of my stories, familial landscapes, curriculum making (Huber, Murphy, & Clandinin, 2011), and my considerable and complex privileges. I am the daughter of first generation Scottish-English, Canadian nursery growers and farmers (Regan, 2010; Rix, Barclay, & Wilson, 2014). Embedded and embodied in my early familial landscapes are stories of family artists and authors, who were and are faith and business leaders, teachers, and nurses (Finlay, 2014). I have been practicing nursing for 35 years. For many years, my practice included working with and alongside Aboriginal nation members and communities.

This work did not include approval from a research ethics board; therefore, it is important to note reflections and imagination as represented poetically and artistically are my own. Knowing this I routinely came into tension because I do not want to tell another’s story and I do not want to contribute to ongoing colonization, yet I am talking about others. Leaning into the work of Kofman (1995, p.5) my intention is to write “without power” and therefore write authentically and ethically (Finlay, 2012). Wyatt (2006, p.815) suggests that “writing without power allows readers to make their own judgement: it allows space for otherness”. Moreover, Strega (2005, p.224) reminds me that “within the system of domination and subordination, where the perspectives of the marginalized are not fully appreciated, those of us who have this experience need to share it, voice it, and give it space”. Mindful of this and desiring to shed light on “power

differentials in society” (Kovach, 2009, p. 110) while working towards becoming an “anti-oppressive researcher” (Potts & Brown, 2005, p. 255) and ally (Regan, 2010) I wonder how my assumptions, beliefs, values and privileges influenced my literature review and in-community clinical practice (Finlay & Gough, 2003).

Grounding a Reflexive Practice

Our reflective practice deepened understandings (Finlay, 2012; Schon, 1983). We learned about ourselves. Janet narrowed her research topic and we came to appreciate what Greene (1977) described as wide-awakeness:

By the term wide-awakeness we want to denote a plane of consciousness of highest tension originating in an attitude of full attention to life and its requirements. Only the performing and especially the working self is fully interested in life and, hence, wide-awake. It lives within its acts and its attention is exclusively directed to carrying its project into effect, to executing its plan. This attention is an active, not a passive one. Passive attention is the opposite to full awareness. (Greene, 1977, p. 121)

My developing wide-awakeness allowed me to begin the process of deconstructing who I am as a white nurse providing care to Aboriginal clients living in-community. It also allowed me to begin to wonder about culturally relevant clinical practices as they relate to Aboriginal people living with diabetic foot ulcers. Moreover, as I continued to read the reflexivity literature, I woke up “perhaps to the way things ought to be” (Greene, 2001, p. 109) and to new tensions. Over time, I learned to rely on art-as-event (Greene, 2001) journaling and collaboration in efforts to name and educatively (Dewey, 1938) navigate tension. I read about lives, forever changed when living with a diabetic foot ulcer (Ribu, Birkeland, Hanestad, Moum, & Rustoen, 2008; Rose et al., 2008; Yao et al., 2012; Young et al., 2016). Reading, working, thinking, reflecting and collaborating I experienced internal tension and sadness. With unpredictable regularity I was flooded by exhaustive memories of people experiencing foot ulcers, surgical debridement, amputations, death, and resultant losses: individual and community.

Story Number Two: Art-As-Event and Collaboration

Memories of those returned from amputation surgery swarm my mind. I recall painstaking attempts to navigate community ferry docks and the steps of coffee shops with an ‘off-loading boot’ or prosthetic limb (see Figure 1).



Figure 1: Offloading Devices for Persons Living with Diabetic Foot

I close my eyes and see shadows, unsteady on canes or walkers and teetering precariously. In stark contrast to robust, loggers, carvers, fishers, and teachers. Frail, haggard and with the facial mask associated with long-term antibiotic usage.

In my journal, reflections fill the page:

Where are the employed persons I once met? What happened to their stories of life on the ocean or in the bush? How will they provide for families and participate in-community? I know amputation statistics! Fifty percent of those with one amputation are deceased within five years (Armstrong, Boulton, & Bus, 2017). Why is a 50% death rate acceptable?

I return to my reflexive practice, including creating art. I make space and time to think empathically about what it means to live with diabetic foot ulcerations. I also think critically about the care provided. This practice helps me identify my psychosocial and spiritual frames, the Eurocentric “values and norms to which ... [I] have given priority and those ... [I] have given less importance” (Schon, 1983, p. 310). Thinking through a societal lens, I am able to wonder about priorities when it comes to diabetic foot health and the wellbeing of Aboriginal people. I created a large oil painting titled “Pause” (see Figure 2).



Figure 2: Pause

Here an Aboriginal leader is standing on the edge of a community with a white nurse. As stories of community health are shared, she listens and hears and pauses (Wright & Leahey, 2006). She learns how losing a limb to diabetes affects the health of the entire community; there is no longer a working mechanic in town, the sports team no longer has a coach and a child no longer sees his parent on the sidelines. The white nurse, trained to seek out empirical data, is at a loss when presented with societal and cultural complexities that often accompany amputation. She sees people losing their jobs and slowly she begins to wake up and push past the limits of her training and education. With this “wide-awakeness” (Greene, 1977, p. 121) and “without the ability to think about yourself, to reflect on your life, there’s really no awareness, no consciousness. Consciousness doesn’t come automatically; it comes through being alive, awake, curious, and often furious” (Greene, 2008, para 2). My training has me maintaining a face of strength; saving my sadness for later. That evening I dig into the literature in efforts to make sense of experiences.

Story Number Three: ‘Two-Eyed Seeing’

Working alongside Aboriginal people, I went in search of knowledge that would provide a scaffold for my training to my ‘in-community’ experiences. I read about Two-Eyed Seeing principles and used them to guide my reflexive practice (see Figure 3).



Figure 3: Source: Integrative Science research program in conjunction with Mi’Kmaq Elders in Unama’ki Cape Breton, Nova Scotia, Canada. Used with permission.

These principles allowed me to think deeply about my Eurocentric training within the context of Aboriginal knowledge systems. Two-Eyed Seeing brings together “individuals from different cultures recognizing and working

with the ontologies, epistemologies, methodologies, and goals in their different worldviews” (Institute for Integrative Science & Health, 2017, para, 1). Western medicine regularly views a person’s health through a scientific lens, including a linear and individualistic approach to well-being. In contrast, Aboriginal communities tend to focus on health and wellness within a circular, community-centered, and inclusive approaches. The Two-Eyed Seeing principles bring together these two knowledge systems (Bartlett et al., 2012; Hatcher et al., 2009; Iwama et al., 2009). Looking through a Two-Eyed Seeing lens

allowed me to broaden and deepen my understandings of what it means to individuals and communities living with diabetes. As well, it provided a lens for me to deconstruct the literature I was reading and the care I was providing. My literature review expanded because Two-Eyed Seeing allowed me to appreciate an individual’s physical state – diabetes, cannot be separate from their spirituality, mental wellbeing and the wellbeing of the community.

Looking through the Two-Eyed Seeing lens, I began to understand how my clinical practice was regularly an inappropriate fit for Aboriginal people living in communities. The hyper-focus on the timely movement of persons through clinical settings was efficient; however, it allowed little time for consideration of spirituality, employment or the implications of diabetes for individuals, families and communities. I reflected on Crowshoe et al’s. (2018) recommendations for management of type 2 diabetes and Indigenous peoples living in Canadian contexts. The authors recommend a focus “on social and cultural aspects specific” to each person while acknowledging “patient connections between adverse life experiences and their capacity for diabetes management” (p. 301).

Story Number Four: Collaboration and Art-As-Event

I return to memories of people living with diabetic foot ulcers, nurses’ debriding and surgeons removing digits and I begin to share my compilation stories with Sandra. In conversation we attempt to think outside a Eurocentric model of care. Sandra is familiar with Two-Eyed Seeing principles; we struggle to imagine up what Two-Eyed-Seeing diabetic foot care would look like. We converse and I am flooded with new memories. I share stories that I understood as grounded in feelings of diminished dignity, reduced physical mobility and unwanted interruptions or loss of employment. The employment loss included changes to relationships with forests, oceans, Mother

Earth and volunteer community-based involvement that was less possible because of foot ulcers and the possibility of amputation (Goodridge, Trepman, & Embil, 2005; Highsmith et al., 2016). Sandra introduces literature that allows us to wonder how complexities influence one’s ability and propensity to “imagine up” (Clandinin & Connelly, 2000) forward looking stories, including relationship with and stewardship of Mother Earth, steady, rewarding employment and contributions to family and community.

We discuss well-intended efforts by employers and industry partners who tried to accommodate employees with diabetic foot ulcers and amputations. Sandra asks, how a person wearing a below-the-knee off-loading boot was accommodated? How will an employee safely drive, sit, stand, walk and navigate the workplace? I describe well-intended efforts focused on moving employees from field roles into office settings. Other efforts involved the provision of hand-controlled vehicles with adapted foot pedals. Some employees endured demotions or reduced hours as their physical stamina or ability to work wavered (Waters & Holloway, 2009). Looking at the issue through the Two-Eyed Seeing lens we recognize employers’ efforts did not and perhaps could not consider knowledge systems grounded in relationships with Mother Earth (Kovach, 2009).

Continuing with a Two-Eyed Seeing lens, I reflect and walk along the rocky ocean shoreline, stable and confident in my gait. My dogs bump against me and I continue unaffected. I wonder and imagine what my mobility would be with a foot ulcer encased in a diabetic shoe or an offloading boot. Looking at the water, I also wonder about connections to Mother Earth. I see fishing boats, ferries, and private crafts coming to and from docks. I feel movement and for the first time in my nursing practice, I wonder what it means to be in relation with oceans, forests and lands; to be generationally, culturally and spiritually connected. I also think about the longevity of Aboriginal communities on Turtle Island⁴ and I am reminded of self as privileged settler (Regan, 2010). I wonder how, or even if, I am capable of understanding the stories shared with me.

An emotionally laden oil painting emerges. The buildings and ocean continue through changes in health; ulcers develop, and amputations occur. The deep dark colours and the conversations depicted reflect the complexity of the disease (see Figure 4). Changes to employment and mobility and self-esteem are a reality when living with a foot ulcer (De Meneses, Blanes, Francescato, Gomes, & Ferreira, 2011; Waters & Holloway, 2009). I ask, how can I support people as they struggle to remain at or return to work? I also wonder how nurses can engage conversations grounded in ontologies that may be unknown or foreign. How does a nurse and doctoral

⁴ Turtle Island is how many Aboriginal communities and nations name North America.

student in psychology respond when asked about her relationship to trees, forests, or Mother Earth? For some, these questions are puzzling; therefore, it may be easier to focus on wound care and if there are any remaining minutes a quick conversation about ulcer risk and amputation prevention.

Can nurses and communities share stories of strength and utilize them in efforts to prevent diabetes, foot ulcers and amputations? When I allow myself, I imagine a way forward that results in the prevention of diabetes. I imagine clinics grounded in knowledge systems of Aboriginal people. However, I know in the current model, limited clinical time precludes it. I wonder how to proceed and who in-community might guide these conversations.



Figure 4: Navigate

Returning to the literature and reminded of stories of strength, I note a paucity of qualitative research studies related to Aboriginal persons living with diabetic foot ulcers (Meatherall et al., 2005; Naqshbandi, Harris, Esler, & Antwi-Nsiah, 2008; Schoen & Norman, 2014). I think about the stamina, resilience and perseverance of people living with an ulcer. This is a silent population; I did not regularly meet them in the literature. I know there are people living in-community and I know there are communities working to support members as they struggle to stay employed. “Within the First Nations, there is ... [a] visible tradition of active and engaged response to the process of colonization that seeks to subvert those processes and reshape Aboriginal destinies in ways that are independent from the designs of the Canadian government (Kelm, 1998, p. 177). Why are these voices and stories missing from the literature? Moreover, if Aboriginal people are receiving nursing support, what parts of it do they find useful? In response to these questions, I went in search of available educational materials in efforts to understand an element of

the support being offered to persons living with diabetic foot ulcers.

Story Number Five: Art-As-Event and Janet’s Search For...

Would culturally appropriate education prevent foot ulcers and therefore amputations?

I value and believe in facilitating and offering diabetic foot education. It has been my experience that knowledge helps. I observed this regularly in-community. As I reflect in a journal entry, I recognize my skepticism as it relates to the education provided. Education efforts feel dis-located and dis-connected from community members and from communities (Canadian Institute for Health Information, 2010). In my reflexive journal, I wrote: My efforts seem futile. Is there a lack of culturally relevant foot care and footwear awareness? When I ask, people struggle to describe preventative actions to save their remaining feet? (J. L. Kuhnke, personal communication, August 2012).

I consider my training that emphasizes prevention. I think about diabetes related education materials, pamphlets, and booklets. I searched my community, libraries, pharmacies, diabetic clinics, physician and nurse practitioner offices for culturally relevant educational materials that might provide recommendations about the prevention of diabetic foot ulcers. I was haunted by what I could not find. Examining the available literature, I noted nothing was written or displayed on the importance of conducting daily self-care foot assessments and of wearing appropriate, professionally fitted footwear. In my reflexive journal, I wrote:

Why are the pamphlets dominated by pharmaceutical interventions? Why are so few focused on prevention? As well, why is there only one pamphlet containing images of Aboriginal doctors, nurses, health care workers, people and contexts? I am thinking about the connections between culturally relevant, and community sensitive education and the unthinkable numbers of people, who every year endure amputations. How is it that I belong to a profession that participates in amputations and creates yearly statistical charts of the staggering and growing numbers of amputations whilst knowing that 85 percent are preventable”. (J. L. Kuhnke, personal communication, Oct 2012).

Regan (2010) states “it is easy, from the safety of our relatively comfortable lives, to judge the apparent inability of Native people to rise above such conditions, thus pathologizing the victims of our well-intended actions” (p. 11). How then do I

undo and reframe my training and years of practice? Heilbrun (1997) reminds me of "... dis-similarities of opportunity that race, class, gender, and national origin enforce and reinforce in our culture" (p. 49).

Feeling the weight of the statistics, I went in search of communities who are working to interrupt oppressive narratives that can lead to health issues. I met members advocating for changes to nutritional choices available in schools. I encountered communities working to reduce the number of fast-food ventures on or at the edge of their communities. Walking on community paths and around sport field perimeters, we talked of diabetes risk reduction activities (Crowshoe et al., 2018) because each of us prefers to walk on two healthy feet.

Lingering and repeating Wagamese's (2016) art-as-event and poetic reference to feet, I understand, acknowledge and feel how important it is to: "walk gently ON THE EARTH and do each other NO HARM" (p. 34) and to "DANCE, dang it, THAT'S WHAT FEET ARE FOR!" (p. 173).

Story Number Six: Art-As-Event and Indian Residential Schools⁵

As we walked, community members alongside, I listened. Stories were shared about caring for oneself and living as survivors of Indian Residential Schools. Indian Residential Schools resulted in "devastating cultural, psychological, and emotional harms and traumatic abuses that were inflicted upon small children- and intergenerational history of dispossession, violence, abuse, and racism that is a fundamental denial of the human dignity and rights of Indigenous peoples" (Regan, 2010, p. 5). I began to wonder about connections between self-care and the legacy of Indian Residential Schools. I appreciated how this fledgling wonder was shaping how and what I read as I continued to compose my literature review. I began reading narratives written by survivors of Indian Residential Schools. The accounts were intense; through the reading I became more informed. I continued to narrow my reading with a focus on Indian Residential Schools and individual and community health. All the while, I attended to my biases and privileges as a white nurse (Maxwell, 2005). I came to know "the negative impact[s] of colonization... [are] still readily apparent" (Kelm, 1998, p. 177) and I began to ask myself how my nursing practice was contributing to the ongoing colonization?

In the midst of these complex wonders I am in the middle of what Finlay (2002b) referred to as "negotiating the swamp" (p. 209). I wake up (Greene, 2001) as I learn about the abuse, neglect and trauma endured by Aboriginal children (Walmsley, 2005). I know some of these children are now adults living with diabetes and they come to clinics where I work. From my familial curriculum making (Huber et al., 2011) I feel challenges to my knowing of what it means to be safe, making the reading hard. I expand my reading of the literature to include memoirs: 'They Called Me Number One' (Sellars, 2013), 'They Came for The Children: Canada, Aboriginal Peoples, and Residential Schools' (The Truth and Reconciliation Commission of Canada, 2012) and 'Broken Circle' (Fontaine, 2010).

In my reflexive journal, I wrote:

I visited the former Indian Residential School and the Secwepemc Museum and Heritage Park in Kamloops, British Columbia (Project of Heart, 2015). I walked the hallways and I imagined hearing the children's calls of distress. I tried to understand with eyes-wide-open, with "wide-awakeness" (Greene, 1977, p. 121) in efforts to know and interrupt my privileges. So many questions came. I wondered how, and if, health, diabetes, and patients' self-care is related to Indian Residential Schools and the trauma, abuse, and neglect endured. Is the development of diabetes and related complications linked to emotional and spiritual health, past, present and future? I spent the remainder of the day writing, walking and praying in the Heritage Park beside the school listening and hoping that the Thompson River which runs past the former Indian Residential School would provide answers; it did not. (J. L. Kuhnke, personal communication, April 2014).

Story Number Seven: Art-As-Event and Patient Pain

As I continue my literature review, I learn about relationships between diabetes, depression, pain and disability (Meatherall et al., 2005; Williams et al., 2010). I learn pain can be chronic, long-term and vary in intensity. Interrelated with physical pain are descriptions of emotional, spiritual, and psychological loss and grief. People describe symptoms of anxiety, fear, depressive symptoms, distress and depression. I wonder if and how diabetes care and foot ulcer outcomes, including amputations, could change if the care provided was culturally relevant and included considerations for emotional and spiritual well-being grounded in Aboriginal knowledge systems.

removed from their homes and communities. Many endured complex and longitudinal abuses.

⁵ Indian Residential Schools were "jointly established and run by the federal government and various churches in most provinces and territories across the country" [Canada] (Regan, 2010, p. 4). Aboriginal children were forcibly

In my reflexive journal, I sketch images in efforts to understand my perspectives on pain. The 'Oppression of Chronic Pain' (see Figure 5) oil painting emerged using painting-knives on a large canvas, as no canvas seems capable of containing the pain and my tensions. Rich colours emerged as I strived to reflect my understanding of living with pain.

This oil painting is my effort to illustrate and imagine the pain experienced by those living with diabetic foot ulcers as they encounter and navigate multiple changes. The colour red symbolizes blood, pain and infection. The diabetic foot ulcer is the red moon. The red in the individual's hair reflects personal pain and the dark circles seen under the eyes mirror fatigue and drawn weariness from long-term use of antibiotics. The red on the side of the mills, factories, and buildings where people were employed prior to development of a foot ulcer symbolize conflict.



Figure 5: The Oppression of Chronic Pain

With job change or loss there is often the accompanying loss of medical and extended benefits. This may interfere with access to professionally fitted diabetic shoe inserts or specialized walking aids. In pain and without access to the necessary financial resources people may purchase over-the-counter 'solutions' that are economical; however, may result in harm. The following poem was created to describe preventable foot ulcers (see Figure 6).

I hold feet...
 often a purplish hue
 digits missing...

The surgeon weighs in:
 the heel is eroded; it's got to go!

She picked up her shoes and looked inside...
 "Extended benefits cut off – feet were infected and aching
 \$29.99 shoe insert was a bargain solution"

A foot eroding solution...

and...

Her Pain
 Deep black, drawn circles encase her sunken eyes
 A plastic bag with numerous, prescriptions and a dangling
 intravenous port
 She wanted to see nurses before her amputation surgery;
 she wanted time with those she trusted

Statistics cast long, deathly shadows
 we imagined her gone within five years

Figure 6: \$29.99 Over-the-Counter "Bargain"

Using my eyes and hands, I debride and bandage. In the midst of providing care, I am keenly aware of my inability to feel the complex physical pain associated with diabetic foot ulcers. I attempt to isolate this inability and lay it alongside my emotional response to pain endured by family members. I do this in efforts to deepen my understandings of the tentacles of pain. My efforts emerged and I imagined up these energies in the following poem: "Listening" (see Figure 7). Pain is intimate and individually endured. As practitioners we often underestimate it.

I see pain; I want to fix it
 I feel pain; I want to fix it
 I hear pain; I want to fix it
 I sense pain; I want to fix it
 and...

I listen as you share stories of pain, and
 I listen again, again and again,
 I reflect again, again and again
 and I begin to hear you
 I begin to appreciate
 what I know about pain, I can place within a piece of sand,
 I continue, grateful for your willingness to share stories

Figure 7: Listening

Waking Up and Moving Forward...

As I lived out a reflexive practice, I recognized my efforts: Two-Eyed Seeing, art-as-event, and collaboration delivered me to the door of what Clandinin (2013) described as “so what? and who cares?” (p. 35). What had I learned that would benefit myself and others moving forward?

When I began this work, I was a doctoral student, assigned a reflexive practice as part of a course on qualitative research methodologies. When I went to the literature, there was a paucity of student written papers on the topic of reflexivity. As I read and engaged in reflexivity, I understood it holds significant potential for learning and deconstructing (Finlay, 2002a, 2002b; Greene, 2001). Through time as my reading, thinking, collaborating, and creating diversified I came to understand a reflexive practice as a safe space where I could shred the shroud of western all-knowing and begin to ask questions and investigate matters often left unspoken (Regan, 2010). I was able to consider white privilege (Nix et al., 2014), to read about it and wonder how it shapes my clinical practice, the relationships I develop and the literature I reviewed. I also began to wonder how my white nurse privilege makes me complicit in ongoing colonization as it relates to the provision of care for people and communities living with diabetic foot ulcers.

Reflexivity also afforded a space where I could tentatively wonder how to shift my stories from those that contribute to ongoing colonization towards reconciliation. Regan (2010) reminds me “I unravel the Canadian historical narrative and deconstruct the foundational myth of the benevolent peacemaker- the bedrock of settler identity- to understand how colonial forms of denial, guilt, and empathy act as barriers to transformative socio-political change” (p. 31). Through my reflexive practice I begin to unravel my own stories, such that I tentatively seek out opportunities to engage in transformative socio-political change.

Two-Eyed Seeing principles informed my reflexive practice. Looking through the lens, I had many wonders: How might health care practices and systems be different if we acknowledge, respect and integrate Aboriginal knowledge systems? How might nurses, psychologists, therapists, and doctors ask about unfamiliar experiences, beliefs, views, and understandings? How can we honour experiences and embed other types of knowing into our respective practices? How can we participate in spaces where culturally diverse stories from homes, families and communities are welcomed, shared and valued as part of composing a life with diabetes and as part of an interdisciplinary health care team and system? Returning to Lessard, Caine, and Clandinin (2015), they state that we

need to learn to honor the richness of multiple worlds..., neither to erase or write over other worlds not to privilege one world over another. [This] we imagine, is particularly important for... [people living with diabetic foot ulcers] whose lives are usually seen in the more stereotypical and deficit ways. (p. 210)

Two-Eyed Seeing also led me to know that “only by attending closely to the multiple worlds of ... [people and communities living with diabetic foot ulcers] will we, as researchers, professionals, as people, be able to understand the experiences” (Lessard et al., 2014, p. 210).

Art-as-event (Greene, 1995) allowed space to move thinking from my mind, through my body to the page and canvas. As my thinking moved, it shaped and reshaped as I continued to read, think and discuss. Each time I engaged in art-as-event, I was afforded opportunities to hear other voices, voices which for most of my education were silenced. Visiting the former Indian Residential School and walking the halls, I was able to use my mind and body to begin to empathically imagine the hell students endured. In so doing, and in a small way, I engaged in the process of deconstructing privilege. I understood the children that attended were youngsters like I was once, members of families and communities, like I was.

They were loved by their parents, like I was. And yet, I was not taken from my home and forced to attend. What was the difference? The children were Aboriginal and I am white. Art-as-event gently led me inside this knowing. I began to think about who I am as an uninvited settler and who I might become as a supportive ally. Greene (1995) reminds us:

We see; we hear; we make connections. We participate in some dimensions that we could not know if imagination were not aroused. Only the imagination can get us out of the bind of the eternal present, inventing or hypothesizing or pretending or discovering a way that reason can then follow into an infinity of options. (p. 186, 187)

On this day, I do not have an infinity of options; however, through collaboration, I do have a few ideas. These ideas were possible through my engagement with art-as-event.

I return to the story that began this article and I think about the stored energy that resided in my legs as I waited to scoot across the clinic floor, to the foot of stretchers and chairs to begin debridement. I think about the moments when I waited and how I might use them to reconsider or change nursing practices. It is in the moments, that a reflexive practice affords opportunities to think deeply about what we are doing, to move from trained reaction, to deeply thoughtful, well informed responses, including possibilities for other, and in this case, culturally relevant and sensitive nursing practices for community members living with diabetic foot ulcers and for the non-Aboriginal health care professionals.

Finally, my reflexive practice led me to understand Heilbrun (1997) when she wrote “traces, I now believe, are left only by work that has overmastered us, work which we cannot, after, we once begin it, imagine not in our life” (p. 51). For me, it was exciting to write and rethink the reflexive practice and journey in collaboration with an educator outside my discipline (Riddell, 2018). As we continue as a collaborative team, we are grateful for the opportunity to begin to create traces.

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References

- Armstrong, D. G., Boulton, A. J. M., & Bus, S. A. (2017). Diabetic foot ulcers and their recurrence. *The New England Journal of Medicine*, 376, 2367-2375. doi:10.1056/NEJMra1615439
- Bartlett, C., Marshall, M., & Marshall, A. (2012). Two-eyed seeing and other lessons learned within a co-learning journey of bringing together Indigenous and mainstream and ways of knowing. *Journal of Environmental Studies and Sciences*. Retrieved from <http://www.integrativescience.ca/uploads/articles/2012-Bartlett-Marshall-Integrative-Science-Two-Eyed-Seeing-JESS.pdf>
- Battiste, M. (2013). *Decolonizing education: Nourishing the learning spirit*. Vancouver, BC: Purich.
- Bishop, E. C., & Shepherd, M. L. (2011). Ethical reflections: Examining reflexivity through the narrative paradigm. *Qualitative Health Research*, 21(9), 1283-1294.
- Brookfield, J. D. (2015). *The skillful teacher* (3rd ed.). San Francisco, CA: Jossey-Bass Wiley Publishers.
- Canadian Institute of Health Research. (2010). *Talking with their feet: Non-attendance of Aboriginal people at diabetes clinic*. Author: B.L.Paterson. University of New Brunswick, Canada. Retrieved from <http://www.integrativescience.ca/uploads/activities/Talking%20With%20Their%20Feet.pdf>
- Canadian Institute of Health Research. (2011). *CIHR institute of aboriginal people's health strategic plan 2014-2018*.
- Clandinin, D. J., & Connelly, F. M. (2000). *Narrative inquiry*. San Francisco, CA: Jossey-Bass.
- Clandinin, D. J. (2013). *Engaging in narrative inquiry*. Taylor & Francis Group.
- Crowshoe, L., Dannenbaum, D., Breen, M., Henderson, R., Hayward, M. N., & Toth, E. (2018). Type 2 diabetes and Indigenous peoples. *Canadian Journal of Diabetes*, 42, S296-S306. Retrieved from <http://guidelines.diabetes.ca/docs/cpg/Ch38-Type-2-Diabetes-and-Indigenous-Peoples.pdf>
- De Meneses, L. C., Blanes, L., Francescato, D., Gomes, H. C., & Ferreira, L. M. (2011). Health-related quality of life and self-esteem in patients with diabetic foot ulcers: Results of a cross-sectional comparative study. *Ostomy Wound Management*, (March), 36-43.
- Dewey, J. (1938). *Experience and education*. New York: Macmillan Company.
- Diabetes Canada. (2018). The Canadian diabetes association 2018 clinical practice guidelines for the prevention and management of diabetes in Canada. *Canadian Journal of Diabetes*, 42 (Suppl.1), S1-S342. Retrieved from <https://guidelines.diabetes.ca/cpg>
- Finlay, L. (2002a). 'Outing' the researcher: The provenance, process, and practice of reflexivity. *Qualitative Health Research*, 12(4), 531-545.
- Finlay, L. (2002b). Negotiating the swamp: The opportunity and challenge of reflexivity in research practice. *Qualitative Research*, 2(2), 209-230.
- Finlay, L. (2012). Five lenses for the reflexive interviewer. In J. Gubrium, J. Holsteir, A. Marvasti & J. Marvasti (Eds.), *Handbook of interview research*. CA: Sage Publications.
- Finlay, L. (2014). Embodying research. *Embodying Research, Person-Centered & Experiential Psychotherapies*, 13(1), 4-18. doi:10.1080/14779757.2013.855133
- Finlay, L., & Gough, B. (2003). *Reflexivity: A practical guide for researchers in health and social sciences*. Oxford, UK: Blackwell Science Ltd.
- Finley, S., & Knowles, J. G. (1995). Researcher as artist/artist as researcher. *Qualitative Inquiry*, 1(1), 110-142. doi:10.1177/107780049500100107
- Fontaine, T. (2010). *Broken circle*. Victoria, BC: Heritage House Publishing.
- Government of Canada. (2014). Research involving first nations, Inuit, and Metis peoples of Canada. *TCPS2 – Chapter 9*. Retrieved from <http://www.pre.ethics.gc.ca/eng/policy-politique/initiatives/tcps2-eptc2/chapter9-chapitre9/>
- Greene, M. (1977). Toward wide-awakeness: An argument for the arts and humanities in education. *Teachers College Record*, (79), 119-125.
- Greene, M. (1995). *Releasing the imagination: Essays on education, the arts, and social change*. San Francisco, CA: Jossey-Bass.
- Greene, M. (2001). *Variations on a blue guitar*. New York: Teachers' College Press.
- Greene, M. (2007). *Imagination and the healing arts* (pp. 1-4). Retrieved from https://maxinegreene.org/uploads/library/imagination_h_a.pdf
- Greene, M. (2008). Teaching wide-awake (blog post). Retrieved from

- <https://teachingwideawake.wordpress.com/2008/10/14/wide-awakeness/>
- Hatcher, A., Bartlett, C. M., Marshall, A., & Marshall, M. (2009). Two-eyed seeing in the classroom environment: Concepts, approach and challenges. *Canadian Journal of Science, Mathematics and Technology Education*, 9(3), 141-153.
- Heilbrun, C. G. (1997). *The last gift of the time life beyond sixty*. New York: Ballantine Books.
- Highsmith, M. J., Kahle, J. T., Klenow, T. D., Andrews, C. R., Lewis, K. L., Bradley, R. C., Highsmith, & J. T. (2016). *Interventions to manage residual limb ulceration due to prosthetic use in individuals with lower extremity amputation: A systematic review of the literature. Technology Innovation*, 18(2-3), 115-223.
- Huber, J., Murphy, M. S., & Clandinin, D. J. (2011). Chapter 1 interrupting understandings of curriculum making. In J. Huber, M.S. Murphy, D.J. Clandinin (Eds.), *Places of curriculum making (advances in research on teaching, Volume 14)* (pp. 1-10). Emerald Group Publishing Limited.
- Institute for Integrative Science & Health. (2017). *Integrative framework*. Retrieved from <http://www.integrativescience.ca/Themes/Integrative/>
- International Diabetes Federation. (2015). *International Diabetes Federation (IDF) diabetes atlas*. Retrieved from <https://www.idf.org/e-library/epidemiology-research/diabetes-atlas.html>
- Iwama, M., Marshall, M., Marshall, A., & Bartlett, C. M. (2009). Two-eyed seeing and the language of healing in-community-based research. *Canadian Journal of Native Education*, 32(2), 3-23.
- Jootun, D., Mcghee, G., & Marland. G. R. (2009). Reflexivity: Promoting rigour in qualitative research. *Nursing Standard*, 23(23), 42-46.
- Kelm, M.E. (1998). *Colonizing bodies*. Vancouver, BC: UBC Press.
- Kofman, S. (1995). Writing without power a conversation with Sarah Kofman. *Women's Philosophy review*, 13(June), 5-8.
- Kovach, M. (2009). *Indigenous methodologies: Characteristics, conversations and contexts*. Toronto, ON: University of Toronto Press.
- Lessard, S., Caine, V., Clandinin, D. J. (2015). A narrative inquiry into familial and school curriculum making: Attending to multiple worlds of Aboriginal youth and families. *Journal of Youth Studies*, 18(2), 197-214.
- Lincoln, Y.S., & Guba, E.G. (1985). *Naturalistic inquiry*. Newbury Park: Sage Publications.
- Loewen, K., Vigliarolo, J., Lance, B., Rockley, M., Schreiber, Y., Kivi, C., Dwyer, C., & Kelly, L. (2017). Rates of diabetes-related lower-limb amputation in northwestern Ontario: An incidence study and introduction of a standardized diabetic foot ulcer management protocol. *Canadian Journal of Rural Medicine*, 22(3), 100-107.
- Marshall, A. (2012). *Two-eyed seeing etuaptmuk: Presentation for Chapeau first nation*. Retrieved from <http://www.integrativescience.ca/uploads/articles/2012Feb-Marshall-Two-Eyed-Seeing-Chapeau-First-Nation.pdf>
- Maxwell, J. A. (2005). *Qualitative research design*. Thousand Oaks: Sage Publications.
- McCabe, J., & Holmes, D. (2009). Reflexivity, critical qualitative research and emancipation: A Foucauldian perspective. *Journal of Advanced Nursing*, 65(7), 1518-1526.
- Meatherall, B. L., Garrett, M. R., Kaufert, J., Martin, B. D., Fricke, M. W., Arneja, A. S., & Embil, J. M. (2005). Disability and quality of life in Canadian Aboriginal and non-Aboriginal diabetic lower-extremity amputees. *Archives of Physical Medicine and Rehabilitation*, 86(8), 1594-1602.
- Nabuurs-Franssen, M.H., Huijberts, M.S.P., Nieuwen Huijzen Kruseman, A.C., Willens, J., & Schapter, N.C. (2005). Health-related quality of life of diabetic foot ulcer patients and their caregivers. *Diabetologia*, 48, 1906-1910.
- Naqshbandi, M., Harris, S. B., Esler, J. G., & Antwi-Nsiah, F. (2008). Global complication rates of type 2 diabetes in Indigenous peoples: A comprehensive review. *Diabetes Research and Clinical Practice*, 82, 1-17.
- Potts, K., & Brown, L. (2005). Becoming an anti-oppressive researcher. In L. Brown, & S. Strega (Eds.), *Research as resistance: Critical, Indigenous, and anti-oppressive approaches* (pp. 225-286). Toronto, ON: Canadian Scholars' Press.
- Projects of Heart (rev 2015). *Illuminating the hidden history of Indian residential schools in British Columbia*. Retrieved from <https://bctf.ca/HiddenHistory/eBook.pdf>
- Rae, J., & Green, B. (2016). Portraying reflexivity in health services research. *Qualitative Health Research*, 26(11), 1543-1549.
- Regan, P. (2010). *Unsettling the settler within*. Vancouver, BC: UBC Press.
- Riddell, J. (2018, November). Changing the rules: Using productive disruption in higher education. *University Affairs*, p. 46.
- Rose, G., Duerksen, F., Trepman, E., Cheang, M., Simonsen, J.N., Koulack, J., & Embil, J.M. (2008). Multidisciplinary treatment of diabetic foot ulcers in Canadian Aboriginal and non-Aboriginal people. *Foot & Ankle Surgery*, 14(2), 74-81. doi:10.1016/j.fas.2007
- Ribu, L., Birkeland, K., Hanestad, B.R., Moum, T., & Rustoen, T. (2008). A longitudinal study of patients with diabetes and foot ulcers and their health-related quality of life: Wound healing and quality-of-life changes. *Journal of Diabetes and Its Complications*, 22, 400-407.
- Riddell, J. (2018, Oct 1). Changing the rules: Using productive disruption in higher education. *Adventures in Academe*. Retrieved from <https://www.universityaffairs.ca/opinion/adventures-in-academe/using-productive-disruption-in-higher-education/>
- Rix, E. F., Barclay, L., & Wilson, S. (2014). Can a white nurse get it? 'Reflexive practice' and the non-Indigenous

- clinician/researcher working with Aboriginal people. *Rural and Remote Health*, 14(2), 2679.
- Saldana, J. (2011). *Fundamentals of qualitative research*. New York: Oxford Press.
- Schofield, D.J., Percival, R., Passey, M.E., Shrestha, R.N., Callender, E.J., & Kelly, S.J. (2012). The financial vulnerability of individuals with diabetes. *British Journal of Diabetes and Vascular Disease*, 10, 300-304. doi:10.1177/1474651410385864
- Schon, D.A. (1983). *The reflexive practitioner: How professionals think in action*. Basic Books.
- Schoen, D. E., & Norman, P. E. (2014). *Diabetic foot disease in Indigenous people*. *Diabetes Management*, 4(6), 489-500.
- Sellars, B. (2013). *They call me number one*. Vancouver, BC: Talon Books.
- Smith, L. T. (2008). *Decolonizing methodologies*. New York: St. Martin's Press, LLC.
- Strega, S. (2005). The view from post structural margins: Epistemology and methodology reconsidered. In L. Brown & S. Strega (Eds.), *Research as resistance* (pp.199-236). Toronto, ON: Canadian Scholars' Press.
- The Truth and Reconciliation Commission of Canada. (2012). *They came for the children: Canada, Aboriginal peoples, and residential schools*. Ottawa, ON: Author.
- The Truth and Reconciliation Commission of Canada. (2017). *Truth and reconciliation report and recommendations*. Retrieved from <http://cfla-fcab.ca/wp-content/uploads/2017/04/Truth-and-Reconciliation-Committee-Report-and-Recommendations.pdf>
- Wagamese, R. (2014). *Embers: One obibway's meditations*. Maderia Park, BC: Douglas & Macintyre.
- Walmsley, C. (2005). *Protecting Aboriginal children*. Vancouver, BC: UBC Press.
- Waters, N., & Holloway, S. (2009). Personal perceptions on the impact of diabetic foot disease on employment. *The Diabetic Foot Journal*, 12(3), 119-131.
- Williams, L.H., Rutter, C.M., Katon, W.J., Reiber, G.E., Ciechanowski, P., Heckbert, S.R., & Von Korff, M. (2010). Depression and incident of diabetic foot ulcers: A prospective cohort study. *The American Journal of Medicine*, 123(8), 748-753.
- Wright, L. M., & Leahey, M. (2006). *Nurses and families: A guide to family assessment and intervention*. Philadelphia: F. A. Davis Company.
- Wyatt, J. (2006). Psychic distance, consent, and other ethical issues. *Qualitative Inquiry*, 12(4), 813-818.
- Yao, H., Ting, X., Minjie W., Yemin, C., Xiqiao, W., Yazhi, J., & Shuliang, L. (2012). The investigation of demographic characteristics and the health-related quality of life in patients with diabetic foot ulcers at first presentation. *The International Journal of Lower Extremity Wounds*, 11(3), 187-193. doi:10.177/1534734612457034
- Young-Hyman, D., de Groot, M., Hill-Briggs, F., Gonzalez, J. S., Hood, K., & Peyrot, M. (2016). Psychosocial care for people

with diabetes: A position statement of the American diabetes association. *Diabetes Care*, 39, 2126-2140. doi:10.2337/dc16-2053

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