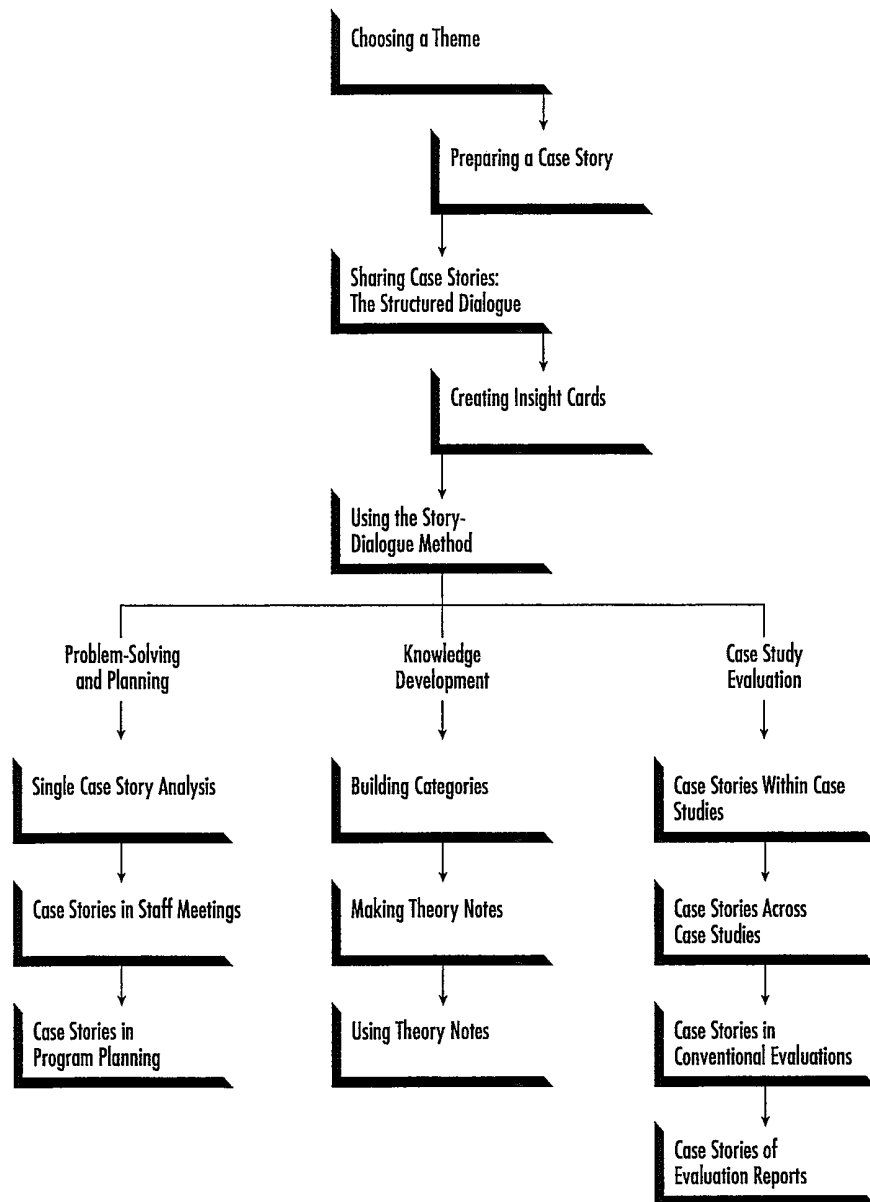


Figure 2: Steps in the Story-Dialogue Method and its uses



## THE QUESTION CATEGORIES, AND THE QUESTION OF VALIDITY AND GENERALISABILITY

Four categories of open questions are used to generate a structured dialogue:

1. What do you see happening here? (Description)
2. Why do you think it happens? (Explanation)
3. So what have we learned from our own experiences? (Synthesis)
4. Now what can we do about it? (Action) (adapted from Vella, 1989).

A number of prompts exist for each question category, and are often tailored to the specific generative theme (see Table 1 for the prompting questions). These question categories, and their prompts, serve as guides for the structured dialogue. Although the four questions and their prompts are not intended to be used in a linear fashion, providing time for each question category helps to prevent discussion from bogging down in description. While some practitioners find the structure awkward at first, "We needed it. Without it, we would never have dug deeper into our stories" (Feather and Labonte 1996)3.

What? questions invite people to describe what is happening in their case story from their own vantage point. They ground the analysis in experience.

Why? questions invite a discussion on causes, where participants begin to interpret or make sense of what has been described. An important point in explanation is validity: How do participants know that their explanations accurately reflect what happened, or offer the best understanding? Validity here does not mean that the method generates "truth" in a universal sense, but that its findings have "the quality of being well-founded" on experience (Heron 1988), and represent a diversity of opinions that create "saturated" categories (Strauss 1987) that are "grounded" in the description of actual events (Glaser and Strauss 1967). In other words, validity means that a good explanation is understandable and credible, and that it reflects what happened and not just what practitioners wanted to see happen (Razack 1993). This requires a return to the description of the story: What more details are needed to know that the explanation is a valid one? Does the explanation cover all of the story details, or has it selected those that fit well and ignored others that do not?

So what? questions invite a synthesis of what has been learned. The purpose of the story/dialogue method is to identify generalisable practical lessons based on an analysis of experience. Heron (1988) argues that postpositivist research findings, such as those created through the story/dialogue method, should be generalisable or replicable. He does not mean this in the positivist sense, in which the same actions should be transferable to other locales with similar results. Rather, he argues for a "creative metamorphosis," in which the underlying "wisdom" gained is shared with persons facing similar situations. This requires the knowledge claims to be of sufficient depth (specificity) and abstraction (generalisable statements) that others in similar situations can make use of them.



*Table 1: Prompts for Question Categories***DESCRIPTION (WHAT?) QUESTIONS**

- What was the identified partnership need, or problem or issue?
- Who identified it, that is, how did it arise?
- Who initiated the partnership actions?
- What plan or strategy did we have in mind when we started?
- What were our goals and objectives? How did they change over time?
- What did we do? What steps were taken in developing the partnership?
- How did we do it?
- What were our successes?
- What were our problems?
- How were decisions made?
- How did we and others in the partnership relate to one another?
- How did it end? or What stage is it presently at?

**EXPLANATION (WHY?) QUESTIONS**

- Why did we choose to partner?
- Whose interests were most served by the way in which the partnership problem or issue was named?
- Why did we do what we did (the strategies or actions)?
- Why do we think it promoted the organisational health of the partners?
- Why do we think it worked?
- How do we know we are right in our assessments of its success?
- What personal/professional skills helped make the work successful?
- What organisational structures or relationships helped make the work successful?
- What did we find frustrating or disappointing about the project, and why?

**SYNTHESIS (SO WHAT?) QUESTIONS**

- What have we learned about partnerships?
- What remains confusing?
- How have people changed through the partnership process?
- How have organisations changed through the partnership process?
- How did relationships between people and organisations change in the partnership process?
- What unexpected spin-offs occurred?



### ACTION (NOW WHAT?) QUESTIONS

- What will we do differently next time?
- What will be our next set of actions?
- What power do we have to do things more effectively in the future?
- How can our power to act more effectively be increased?

The story/dialogue method begins with specific practice experiences (the individual case story) and ensures that efforts are made to extract important lessons for all practitioners from the particular case, “an in depth-analysis of an experience,” as one recent workshop expressed. In most uses of the method, generalisability is strengthened by using two or three different stories on the same theme in each story group, subject to the same structured dialogue. It then works up the results to a more abstract, or “second-level” synthesis of practice.

The purpose of creating generalisable practical lessons is not for theory-building or research “because we want to put it into textbooks. We need to improve our practice, and we need to defend our practice better to our funders” (Labonte and Feather 1996). The Now What? questioning translates what participants thought was significant about the story into new actions.

### STORY GROUPS

Story groups typically average 5 to 9 participants. One person is a story-teller, four persons volunteer for the dual role of story-recorders/story-listeners and the rest are story-listeners. Story-recorders are asked to listen for significant comments in the dialogue made under each question category, and to note them in point form. The purpose of recording the dialogue in this way is two-fold: To provide participants with a practice opportunity in a participant/observation technique, and to ensure that the dialogue remains the data base for later “second level synthesis.” Story groups begin with a verbal telling of the story. This is followed by a “reflection circle,” in which other group members, one at a time and without dialogue, reflect upon and speak to how the story and the issues it addresses are similar to (or different from) their own experience.

“Placing ourselves in the story we heard was very powerful. It stopped us from jumping in to solve the story-teller’s problems. It raised the dialogue to another level. It made us speak from the heart as well as from the mind” (Labonte and Feather 1996).

### INSIGHT CARDS

Each story-telling round concludes with the generation of insight cards. Participants collectively document a number of insights about practice based on the dialogue around the story. This is the point where story-recorders’ notes play a role, to obviate the risk of some persons reaching personal conclusions ungrounded in discussion points on actual experience. Between 10 and 15 insight cards are generated for each story and posted on a wall.



Each round of story-telling, reflection, structured dialogue and generation of insight cards takes between 90 minutes and 2 hours. Depending on the learning format where the method is used, up to three stories can be subjected to the process in a day long workshop. It is also at this point that various applications of the method diverge. No application bypasses the process outlined so far, but none end simply with the generation of insight cards.

#### APPLICATIONS OF THE STORY/DIALOGUE METHOD

Participants in all applications of the method immediately grasp its logic and envision multiple ways in which it can be used in their work, in teaching, team-building, program planning, community development, evaluating community-based health programs, strengthening public/community health nursing practice and so on. Figure 2 outlines only those uses to which its developers have applied it, or conceptualised its application. Most use of the method to date has been to create better health promotion practice knowledge, in which health promoters from many organisations and different organisational levels come together to share stories crafted around the same or similar generative themes. When many case stories are shared for the purpose of knowledge development, a second-level synthesis of the insight cards occurs. There are three steps involved in a second-level synthesis:

1. Building categories from the insight cards.
2. Writing theory notes based on the categories.
3. Sharing theory notes with participants from other story groups.

Categories allow participants to consolidate lessons from a range of stories. There are no firm rules for building categories. Qualitative researchers experienced in this technique talk about “intuition,” “playfulness” and “moving things around until they seem to make sense.”

Qualitative researchers usually form categories working alone, but the process also works well with groups.

“We loved making the categories. It was great to see how issues in our practice, from our practice, started to make sense in a larger way” (Labonte and Feather 1996).

After the categories have been made, story groups write up a descriptive statement that links the statements on the insight cards. This “theory note” is an attempt to explain what is generalisable about the category, what lessons it holds for other practitioners who may be in other practice situations. As one workshop participant stated, “the theory notes allowed me to see how the case story was made useful.” After theory notes are written for each category, they are structured or linked together into a composite theory note, an example of which follows. It is on the theme of community development, important in ensuring participation in health promotion decision-making by less powerful groups. It is taken from a past workshop using the method. (Theory notes on building partnerships are discussed in the next Chapter.)

**COMMUNITY DEVELOPMENT THEORY NOTE**

Health promoters must learn to recognise and encourage the different skills possessed by people they work with. The traditional “deficit” approach looks only for peoples’ problems and reinforces in them feelings of powerlessness. Working from a “capacity” approach that looks for peoples’ skills is more empowering. It is also often the only way health promoters can achieve credibility among community members who are suspicious of “professionals” telling them what to do.

Health promoters need to reflect long and hard on issues, problems and needs in any community before they begin to act. They need to do their homework. They can do this by reading reports. But the most important homework is talking to people—to front-line workers with a longer knowledge of the people in the area, and with people themselves. The guiding question for health promoters in their homework is: “What don’t I know about this community that I need to know before I act?”

Health promoters are often catalysts in communities. Once they have learned about a community’s key issues, they are often initiators of new actions, such as meetings or public events about the issue. This is particularly so if the issue concerns “gaps” in services or access to information. Health promoters are often in a position to share considerable knowledge about these gaps, and how they might be filled.

Health promoters always work with an agenda. This is not wrong, but health promoters need to be upfront and honest with community groups about this agenda, neither pretending it doesn’t exist nor giving false expectations about how far the health promoter and his/her agency can support community group issues and actions.

Group process in communities sometimes takes on a life of its own. Health promoters need to recognise this, and be comfortable in responding to it. They need to have good group process and task skills, and to know when to work with group process and when to concentrate on group task. Health promoters need to be very flexible when they work with community groups. Usually, this comfort and flexibility develops over time. Health promoters can speed this process along to the extent that they:

- strive to be accessible to the group
- are user-friendly in their manners and speech
- balance between being casual (one of the community) and formal (honest about being a professional who works in an agency)
- are respectful of others in the overall way of being.

Composite theory notes can be used for further analysis and dialogue. The example theory note above does not address all of the issues that might confront health promoters seeking to organise a new community group. For example, how many people should health promoters speak with before trusting they have a feel for community issues? Who in any given area is “community”? What should health promoters do if there are strong disagreements in what they

hear? In other words, a theory note not only offers some generalised knowledge about health promotion practice; it also raises new questions about practice that can become generative themes for subsequent story/dialogue meetings.

### USING COMPOSITE THEORY NOTES TO “BENCHMARK” HEALTH PROMOTION EFFECTIVENESS

Composite theory notes can also be used to develop “benchmarks” for evaluating health promotion effectiveness. Benchmarks distill the key actions or changes for which health promoters are accountable. Below are benchmarks based on the community development theory note.

1. Health promoters have a good knowledge of community health issues before they begin.
2. Health promoters have established clear reasons (an agenda) for working with the group, i.e. they know how organising or strengthening this group will improve members' and community health.
3. Health promoters have something to offer the group, e.g. knowledge of health issues, skills in planning and facilitation.
4. Health promoters support the group's own capacity to act on its health concerns.
5. Health promoters help to catalyse broad community action.

In several recent workshops in which theory notes were benchmarked, the term “benchmark” sometimes proved a stumbling block because, in the literature on organisational development, it refers to measuring one's organisational accomplishments against standards set by another “pace-setting” organisation. This is not the meaning implied by the story/dialogue method's use of the term. Another word that might describe this process more accurately is “milestone;” and other story/dialogue workshops have used terms such as “process indicators” or “practice standards” to describe the same points that are extracted from theory notes. What becomes important is ensuring that people understand that, whether they call them “benchmarks,” “milestones,” “indicators” or “standards,” they are creating from their theory notes a temporally related, logically clear set of statements that define what their work achieves, or should achieve. They are translating the normative practice claims contained in theory notes into evaluable statements.

Each benchmark lends itself to development of different indicators which, in turn, lend themselves to different methods for data collection<sup>4</sup>. Examples of indicators for the fourth benchmark above might include:

4. Health promoters support the group's own capacity to act on its health concerns.
  - skills inventory of group members
    - inventory complete
    - inventory considered useful by group members
    - inventory identifies other skills required, not currently present
    - action to obtain skills (training, recruit new members) occurs

- leadership arises within the group
  - members assume responsibility for facilitating group
  - members assume responsibility for planning meetings
  - members generate ideas for taking action
- the group clarifies its own goals and objectives
  - goals and objectives are established
  - goals and objectives are linked to improving health for group members and the broader community
- the group develops and begins to implement actions to reach these goals
  - action planning occurs
  - actions are undertaken
  - actions are evaluated by group members
  - new actions are planned, informed by evaluation of past actions
- the group balances between the emotional needs of its members and taking action on its goals
  - members express satisfaction with group process
  - members express satisfaction with group actions

Such benchmarks can be subject to some tests for their face validity, such as reference to published literature, review by other peers and so on. Community participants should be involved in generating benchmarks, or at least reviewing them (Labonte 1996c). (Also, see Dixon 1995, for a variation of using stories to establish benchmarks and indicators for community development work).

Before undertaking or evaluating any health promotion work, it is important that practitioners have some explanations for how this work promotes health. Explanations should be supported by good research and theory, which is partly the “knowledge of health issues” that health promoters offer to groups. Research informs the development of good explanations and logic models for health promotion practice. Good explanations and logic models inform health promoters and their agencies what is important to evaluate. Some benchmarks may describe process only, and do not lend themselves to an explanation or “logic model” for how health promotion promotes health. But other benchmarks will, and should, for example, numbers 4 and 5 from the community development benchmarks:

4. Health promoters support the group’s own capacity to act on its health concerns.

Enhanced feelings of capacity to act (“empowerment”) is associated with improved health outcomes.

Feeling esteemed in one’s knowledge or skills is associated with improved health outcomes (including, but not restricted to, improved health behaviours).

Improved social relations (“social support”) is associated with improved health outcomes.



#### 5. Health promoters help to catalyse broad community action.

Community group actions can change health determinants such as income and power inequalities, environmental pollution, discriminatory practices and policies (e.g. sexism, racism).

Community group actions can mobilise internal and external (government, private sector) resources required to change health determinants.

Community group actions can influence public and private decision-makers, to ensure “healthier public policies.”

Public policies that influence health determinants are shaped, in part, by mass media and public opinion.

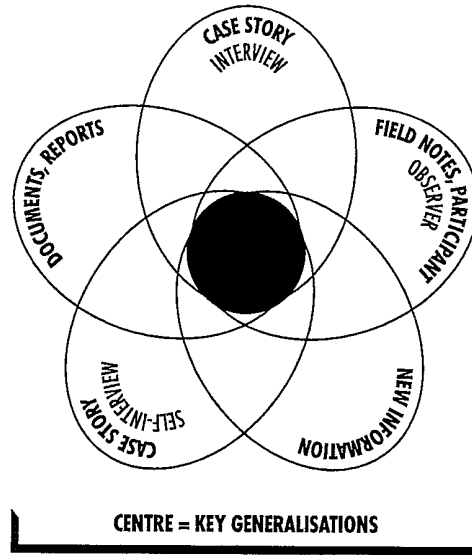
#### USING THE STORY/DIALOGUE METHOD IN CASE STUDY EVALUATION

The method has not yet been applied in any formal case study evaluation. Several applications, however, have been conceptualised, and the role of case stories within case studies is presented graphically in Figures 3 and 4. As part of a case study, case story descriptive notes expand to include details on:

- the community setting (geographic, groups, individuals)
- the organisational setting (including professional roles within the organisation)
- some of the history of the organisation's and the community's past involvement with the problem or issue, and with each other
- other peoples' case stories (interviews)

Participants, staff, supervisors and other key project stakeholders, for example, can prepare case stories around a particular activity or event that is “generative” for the project (a major event, a troubling activity, an unsuccessful attempt). The stories are shared in rounds, ensuring that each story group has story-tellers with different points of view. Insight cards, categories and theory notes are generated, new action strategies are planned and the results of the meeting become part of the evaluation record. Another round of case stories can be developed to evaluate the effects of the new action plans. Inviting many different points of view on the same case stories improves the validity of the stories' lessons. Validity is also improved by using multiple case stories within each case study, e.g. participants' experiences, staff experiences, managers' experiences and so on.

Figure 3: Case Study



Case stories can also be used across case studies, improving the generalisability of the stories' lessons. The method lends itself particularly to projects such as Healthy Communities, Heart Health Coalitions or any other initiative where certain program elements are common across several sites. Project staff from different sites agree on their generative themes. They develop their case stories. They meet to share their stories and to generate new practice insights. New action plans are developed, with agreements between project staff from different sites to try them out. A later round of case stories can be used to determine how well the new strategies worked.

Figure 4:

