HANDBOOK ON USING STORIES IN HEALTH PROMOTION PRACTICE

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CONTENTS

PREFACE 1

ACKNOWLEDGEMENTS 3

CHAPTER 1: INTRODUCTION TO USING STORIES 5

TRADITIONAL USES OF STORY-TELLING 5
THE STORY OF CONVENTIONAL SCIENCE 5
THE RE-EMERGENCE OF THE IMPORTANCE OF STORIES 6
HEALTH PROMOTION AND USE OF STORIES 8

PART I: THE METHOD

CHAPTER 2: INTRODUCING: THE STORY-DIALOGUE METHOD 10

GOALS OF THE STORY-DIALOGUE METHOD 11
STEPS IN THE STORY-DIALOGUE METHOD 11

CHAPTER 3: PREPARING A CASE STORY 13

FOCUS STORY AROUND A THEME 14
WRITE USING "I" OR "WE" 15
PREPARE THE CASE STORY IN ADVANCE 16
CRAFT THE CASE STORY 17
AN EXAMPLE CASE STORY 19

CHAPTER 4: SHARING CASE STORIES: THE STRUCTURED DIALOGUE 23

USE OPEN QUESTIONS 24
QUESTION CATEGORIES 25
THE REFLECTION CIRCLE 26
THE DIALOGUE QUESTIONS 27

Description (What?) Questions 28
Explanation (Why?) Questions 29
Synthesis (So What?) Questions 31
Action (Now What?) Questions 32

STORY GROUP ROLES IN THE STRUCTURED DIALOGUE 33
CONTENTS (Continued) . . .

CHAPTER 5: CREATING TRUST IN SHARING CASE STORIES  37

CHAPTER 6: CREATING INSIGHT CARDS  40

TIMING THE ENTIRE STORY-DIALOGUE METHOD  47

PART II: USING THE METHOD

CHAPTER 7: USING THE STORY-DIALOGUE METHOD  49

USING CASE STORIES FOR PROBLEM-SOLVING AND PLANNING  49

  The Single Case Story Analysis  49
  Using Case Stories in Staff Meetings  50
  Using Case Stories In Program Planning  51

USING CASE STORIES FOR KNOWLEDGE DEVELOPMENT  52

  A Second Level Synthesis  53
  Building Categories  54
  Making Theory Notes  56
  Composite Theory Notes  58
  Using Theory Notes  60

USING CASE STORIES IN CASE STUDY EVALUATION  61

  What is a Case Study?  61
  Case Stories Within Case Studies  64
  Case Stories Across Case Studies  65
  Case Stories in Conventional (Quantitative) Evaluations  65
  Case Stories of Evaluation Reports  65
  Structuring Dialogue Around Case Studies  66

CHAPTER 8: SHARING YOUR EXPERIENCE IN USING THE STORY-DIALOGUE METHOD  67

REFERENCES  69

APPENDIX 1: SOME GENERATIVE THEMES IN HEALTH PROMOTION PRACTICE  73

APPENDIX 2: A GLOSSARY OF TERMS USED IN THIS MANUAL  77
PREFACE

Society is changing its view of how we improve health, and health promotion is central to this change. These changes include: shifting from a focus on disease, diagnosis and medical treatment, to disease prevention and health promotion; promoting healthy lifestyles as well as changing social conditions, such as poverty, powerlessness, environmental damage, and discrimination, that shorten life and increase disease; and recognizing health as a positive experience of well-being and not simply or even at all, the absence of disease.

The challenge for workers in the field of health promotion is to use the most effective methods to accomplish this shift, and to be able to demonstrate to both the communities they work with and to their employers that health promotion can produce greater health for all.

Faced with these challenges, how can the practitioner acquire the knowledge and skills needed to work effectively in health promotion? In addition to formal training, many practitioners tell us that they learn from stories. Sharing stories with their colleagues is an important and valuable technique for problem solving, critical reflection and skill development. But just “telling a story” may not be very revealing. What makes the story-telling an effective learning device is the way the story is constructed, and the way it is examined to reveal its helpful lessons. The purpose of this handbook is to describe a way to use story-telling so that it will strengthen health promotion in practice settings.

The technique we describe was tested in a project called “Sharing Knowledge from Health Promotion Practice.” That study was co-ordinated by the Prairie Region Health Promotion Research Centre (PRHPRC) for Health Canada. A nation-wide Project Team planned and carried out six focus group consultation workshops with health promotion practitioners in all regions of Canada between October and December 1994. The workshops used a “structured dialogue” approach to story-telling. Practitioners found that the process of learning through reflection on experience was very appealing, and made helpful suggestions about how the structured dialogue process could be changed to make it even more effective. They readily saw opportunities to use the technique in their own practice situations for professional development, team building, planning, and evaluation. During regional summer health
promotion institutes in 1995 in Victoria and Toronto, we gained more useful experience with the technique. During a June, 1995 conference in Charlottetown, we explored, with interested practitioners and program managers, how stories are or could be used in practice settings.

This handbook demonstrates our current understanding about how the use of stories can help build a stronger, more effective practice. We recommend its use in health promotion settings of all kinds -- in the community, in clinics and health centres and hospitals, in government and non-government agencies and organizations concerned with improving health or the underlying conditions affecting health. The practitioners who helped refine this process were diverse in background, training, employment situation, geography, language and culture. Our hope is that this handbook will help practitioners of all kinds to take a critical look at their own work, learn from the experience of their peers, and build an even stronger base of knowledge and skills to meet the health promotion challenges of the future.

In the handbook we show how story-telling in health promotion is linked with well-established traditions of using narrative to develop knowledge. In Part I, we discuss how to prepare a story and plan a discussion to uncover the story’s insights. Part II deals with how to use story-telling in professional development, team building, program planning and program evaluation. A Glossary of Terms used in the Handbook is found in Appendix 2.

The Story-Dialogue Method described in this Manual is the result of many experiments in using story-telling. We are sharing what we have learned about its use; we are not saying that we have learned all that we need to know. Bring your own experience and knowledge about story-telling to the Method. We suggest ways you can record your observations about how the technique worked for you, and share those experiences with us. We want to learn from your stories about using story-telling to strengthen health promotion practice!
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  Health Council Workshop in 1994 and the Health Promotion
  Summer Schools in Toronto and Victoria, in June, 1995; in the
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CHAPTER 1

INTRODUCTION TO USING STORIES

The Master gave his teaching in parables and stories, which his disciples listened to with pleasure—and occasional frustration, for they longed for something deeper. The Master was unmoved. To all their objections he would say, “You have yet to understand, my dears, that the shortest distance between a human being and Truth is a story.” (de Mello, 1985)

Few people can resist a good story. Stories are about people and what they do. They offer drama, and emotion. They provide human points of contact that cause us to reflect on our own lives. They touch us in ways that theory arguments and statistical data cannot.

TRADITIONAL USES OF STORY-TELLING

Stories have played a long and important role in our histories. All cultures have story-telling traditions. Before writing, stories were the living libraries of knowledge and the basis of learning. In many First Nations and other aboriginal communities in Canada, and throughout the world, oral history still plays an important role in passing cultural knowledge between the generations.

The aboriginal tradition of the story-telling circle, where each person speaks in turn without interruption, is increasingly used in community meetings and professional gatherings. Its power lies in people speaking from the heart of their experiences, without the threat of interruption or disagreeing challenge.

THE STORY OF CONVENTIONAL SCIENCE

While story-telling remains an important tool in knowledge development in many indigenous communities, its use in Western societies is often overshadowed by conventional scientific methods. These methods of knowledge development seek to understand complex relations in nature and social life by reducing them to specific variables. Experimentation, statistical testing, and repeated study of the same variables gradually build scientific consensus about the world and our place in it. Conventional scientific
methods are very powerful. They have generated important knowledge that all of us use and often take for granted. But when used to study people and their relationships, they may miss or misrepresent important aspects of reality. Some of the practices that give rise to this include making people subjects of researchers’ questions rather than subjects of their own lives; asking questions of interest to researchers, which may not be of interest to the research subjects; interpreting the findings using assumptions that may not be shared by the research subjects; assuming that numbers are “hard,” “objective” data, while peoples’ stories of their own lives are “soft,” “subjective” opinions. These limits to conventional scientific methods have sparked new interest in recent years in the techniques of story-telling, oral history, and narrative.

THE RE-EMERGENCE OF THE IMPORTANCE OF STORIES

Stories, or narratives, are powerful ways to convey experience because only the narrator can give voice to the particularities and meanings that make up our lives. This is significant for many fields of endeavour and inquiry, although it is more widely recognized in some than in others. For example, the systematic use of stories in program planning and evaluation first began in international development work. Aid workers realized that they needed to respect the oral culture of many poor communities. They also discovered that local people had an amazing knowledge about their lives and their environments that conventional research couldn’t tap into. Because conventional researchers weren’t members of that community, they didn’t know the right questions to ask, the right way to ask them or how to use the results.

The contemporary women’s movement was another impetus for using stories to create knowledge. Feminists criticized many of the theories about human behaviour because the science that generated them had ignored women’s voices. When women spoke about their problems, researchers and policy makers (usually men) often dismissed them as “gossip” or “women’s complaints.”

Early consciousness-raising circles of women emphasized the value of women speaking their own experience. In sharing their stories, they learned from one another and developed a body of knowledge about women’s oppression and empowerment.

Story-telling has also become an increasingly important tool in education. Paulo Freire is a Brazilian philosopher who helped to revolutionize how
community workers teach by developing a theory and practice of "critical consciousness" or "popular education." He writes about the power of language in shaping our thoughts and our actions. The first act of power people can take in managing their own lives is "speaking the world." People name their experiences in their own words. Their stories are listened to and respected by others. As the stories are shared between people, they become "triggers" for group reflection and analysis. In this process, people use their own experiences to develop a deeper understanding of the world around them, its effects upon them and their abilities to change conditions that may be harmful.

Qualitative researchers have always used peoples' stories, or narratives, in their work. Instead of numbers, qualitative researchers use words as data--transcripts from interviews or focus groups, field notes of community workers or project participants, minutes of meetings. Most qualitative researchers believe that only in analyzing how people "speak their world" can they understand the meaning people make of their experiences. It is precisely this element of reflection on meaning that is absent from conventional scientific research. Over the past two decades, the scientific and academic community has re-engaged in debates about the role meaning plays in generating scientific knowledge. These debates have given qualitative research methods more prominence, and with it, renewed interest in the use of stories for research, evaluation and knowledge development.

"I'd like to see this (Story-Dilogue) method validated as a legitimate form of qualitative research," Feather and Labonte, 1995

Story-telling as a learning technique is increasingly common in university classrooms, particularly in applied disciplines like nursing, social work and teaching. Story-telling is now being used in legal practice to improve the justice system's understanding of the lives of people whose social oppression often has silenced their voices. Analyses of personal narratives are also becoming more common in the literature on managing organizational change.

Finally, stories play an important role in advocacy. Conventional scientific research generates quantitative evidence that is important for part of the advocates' arguments. The testimony of people affected by policies provides the human faces behind the dry language of bureaucracies and the impersonal abstraction of statistics. The impact on decision-makers can be jarring and powerful.
HEALTH PROMOTION AND USE OF STORIES

The main reason for this Manual is that health promoters and community members themselves recognize the importance of stories in learning, evaluating, planning and gaining a better understanding of their work.

"Ah hah! We've been using stories all along but didn't realize it. Now we can learn how to use them better." CPHA, 1995

Health promotion today means much more than it did 10 or 20 years ago. Health promoters still work one-to-one, providing counselling on a range of personal health issues and lifestyle behaviours. Health promoters continue to plan disease prevention programs, working with groups, communities, coalitions, the media and organizations that span the private and public sectors. But health promoters today are also turning more attention to the social determinants of health, conditions such as poverty, unemployment, pollution, violence, powerlessness and different groups' experiences of discrimination and oppression. Also, preventing disease is no longer the only outcome health promoters wish to achieve. Promoting wellbeing, peoples' experiences of "being healthy," is equally important. These experiences are harder to document than disease and death rates, because they involve peoples' self-evaluations. These self-evaluations are interpretive and highly changeable.

"Story-telling is a creative approach to health promotion knowledge development. It's an excellent process." Feather and Labonte, 1995

Sharing stories—from practice, from the people with whom health promoters work—is one useful method for understanding what today's health promotion practice means, and what it accomplishes. But a concern many health promoters express is that the story form of knowledge won't be taken seriously by their employers or funders. Health promoters want to use stories in their work, but sometimes feel defensive because stories don't fit into conventional scientific methods. The issue is not one of forcing a fit where none exists. Nor is it one of finding a more academic term for story-telling. The issue is one of using stories more rigorously.

"Story-telling is very powerful, but the term belittles it." Feather and Labonte, 1995

Rigour means that we don't accept stories just as they are presented. It means that we use stories as "triggers" to ask probing questions about what was done, why it was done, what it accomplished or means and what we, as a community of health promoters, can learn from them. What makes a good story? Who controls the use of the story? How do
"Don’t just tell me a story. Tell me why this story is a particularly good one.”
Labonte and Robertson, 1994

"(Why) do we shy away from critical reflection of the practices of those on the ‘good’ side(?)"
Razack, 1993

"...when differences or disagreements start to arise, we shouldn’t gloss over them...” Feather and Labonte, 1996

we incorporate stories into our planning and evaluation? How do we ensure that story-tellers do not become just another source of data? How do we use stories in ways that allow us to make credible claims about the knowledge they generate? These are some of the questions this Manual seeks to answer.
PART I:

THE METHOD
CHAPTER 2
INTRODUCING: THE STORY-DIALOGUE METHOD

There are different methods for using stories rigorously in our work. One method is simply to listen to a story and reflect upon it in a personal way. This is the way we read stories or enjoy the oral craft of story-tellers. Another way is to engage with others, including the story-teller, in a dialogue about the story. The method described in this Manual is based on dialogue. More particularly, the technique it uses is called a "structured dialogue." The combination of the story and the structured dialogue is called the Story-Discourse Method. The basic model of the Story-Discourse Method is shown in Figure 1.

**Figure 1: Story-Discourse Method**
A philosopher once noted that we develop knowledge from our own experiences, but wisdom comes when we learn from the experiences of others.

In the centre is the reflective practitioner—you! At every stage in the Story-Dialogue Method you will be reflecting on how what you hear and learn from others has meaning for you personally. You are surrounded by an organization as willing as you to learn about new practices, and by a practice community willing to take the personal risks that learning with stories requires. In turn, you are surrounded by a community of many individuals, groups and organizations, some in harmony, some in conflict, many of whom you wish to support along a path of healthy transformation.

GOALS OF THE STORY-DIALOGUE METHOD

The goals of the Story-Dialogue Method vary according to what practitioners and community people wish to learn with their stories. Generally, the Story-Dialogue Method has been developed with these goals in mind:

1. To tap into the knowledge practitioners and community members gain through reflection on their own practice experiences;

2. To help practitioners and community members share their practice knowledge with one another more effectively;

3. To create more generalized knowledge about practice, from practice, for practice;

4. To incorporate practice knowledge in project evaluations.

STEPS IN THE STORY-DIALOGUE METHOD

Figure 2 shows the sequence of steps in the Method as they are described in subsequent chapters of this Manual. Page numbers refer to sections of the Manual where you will find detailed discussion of each step.
Figure 2: Steps in the Story-Dialogue Method and Its Uses

Choosing a Theme  
(p. 14 - 15)

Preparing a Case Story  
(p. 16 - 22)

Sharing Case Stories:  
The Structured Dialogue  
(p. 23 - 39)

Creating Insight Cards  
(p. 40 - 47)

Using the Story-Dialogue Method  
(p. 49 - 66)

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Problem-Solving  
& Planning

Single Case Story Analysis  
(p. 49)

Case Stories in Staff Meetings  
(p. 50 - 51)

Case Stories in Program Planning  
(p. 51 - 52)

Knowledge Development

Building Categories  
(p. 54 - 55)

Making Theory Notes  
(p. 56 - 60)

Using Theory Notes  
(p. 60 - 61)

Case Study Evaluation

Case Stories Within Case Studies  
(p. 64 - 65)

Case Stories Across Case Studies  
(p. 65)

Case Stories in Conventional Evaluations  
(p. 65)

Case Stories of Evaluation Reports  
(p. 65)
CHAPTER 3
PREPARING A CASE STORY

The core element in the Story-Dialogue Method is the story itself. What makes a good story?

* It is chosen for a particular purpose; for example, it relates to a theme or issue.

* It comes from your own experience.

* It is prepared in advance of the telling of the story.

* It contains key elements: description, explanation, and reflection.

**Case Stories and Case Studies**

This Manual distinguishes between two terms: case story and case study. While the Story-Dialogue Method can be used for many purposes, two of these purposes include research and program evaluation, where the distinctions between case story and case study are particularly important.

The first person narratives you will prepare are called case stories. They are self-interviews that you share with others in a structured dialogue. A case story is personal. It concerns your particular experiences in a particular situation or program. It focuses upon particular events in your practice experience that were difficult, puzzling or especially instructive for you.

The difference between a case story and a case study is the source and amount of rigorous detail used. A case study is an attempt to incorporate more project materials into the structured dialogue. These might include minutes of meetings, project reports, process evaluation reports, and so on. A case study also includes other project participants’ ideas or explanations (their own case stories) about the project. These might be shared in a Story-Dialogue meeting with other participants. They are also often obtained through interviews. Other sources of evidence (data) used in a case study include archival records, such as government reports or surveys, and our own participant-observer field notes.

A case story is a building block for a case study. A case study evaluates our projects using case stories.

Chapter 7 discusses the use of case stories in creating case studies in more detail.
FOCUS STORY AROUND A THEME

What should a case story be about? It depends on what you want the Story-Dialogue Method to do: Is it to help health promoters develop a more critical knowledge of their practice? Is it part of a program evaluation? Is it to help in planning a new program? Is it to help build teams, or part of a professional development training program?

Whatever the purpose, good stories always have themes. A good case story is focused around certain themes.

Case story themes should be important to both the story-tellers and the story-listeners. Popular educators often speak of “generative themes.” A generative theme is an issue that creates animated conversation among people. Case stories are one way to represent (re-present) the theme. Case stories become triggers or starting points for a deeper analysis and understanding of the theme. One reason a theme generates discussion is that it identifies the tensions or strained relations that exist within and between the people who are part of it.

In health promotion, these tensions or strained relations usually pertain to how practitioners conceptualize, implement or evaluate their practices. Health promoters may be unclear about many aspects of their practice, or feel pulled in different directions.

Tension is not necessarily a bad thing. Some tension is needed to create and store energy in a system. But only when the tensions are released, for instance, in writing and dialoguing around the story, does its stored energy flow.
Generative Themes

The Story-Dialogue Method requires organizers to think carefully about generative themes. Prior to the 1994 Health Promotion Knowledge Development Project that piloted the Story-Dialogue Method, organizers reviewed reports of previous health promotion workshops and meetings across Canada, looking for generative themes: What were most health promoters talking about with most passion? The same process has been used for all uses of the Story-Dialogue Method since. Sometimes these themes are found in reports. Other times they are identified by talking with practitioners who would be developing their case stories.

Several of the health promotion generative themes used so far in the Story-Dialogue Method are described in Appendix 1. These themes may speak directly to organizers who want to use the Method. Or they might give organizers of a Story-Dialogue meeting ideas on how to write up a generative theme.

WRITE USING "I" OR "WE"

"We often use other peoples' stories in our work. But what we really need to do is make ourselves the subjects of our own stories." CPHA, 1995

"I'm a program manager, and the story I want to talk about concerns community groups our program funds. Isn't it about them, about their story?" Tell the story from the perspective of what you did as a program manager that affected the community groups' work. Don't take on their story as your story. Examine the role you played in it." Sharing Knowledge, 1994

The most important element of a good case story is that it comes from your own experience. It should tell what you did and how events unfolded from your point of view. If the case story involves other people, make it clear what you did that affected their actions, why you did it and how it had an impact on others. Write from the point of view of "I" or "we," not "she," "he" or "they."
PREPARE THE CASE STORY IN ADVANCE

Case stories are best prepared in advance. Case stories are the building blocks of the Story-Dialogue Method. The more thought people give to their case stories, the more productive the dialogue becomes for everyone.

"Writing the story down was really important for me. I felt more validated as a practitioner."  
University of Victoria, 1995

The process of writing your case story will help you to focus on what is important to share with others. The very act of writing often prompts new insights into practice. The written case story also helps both you and your story-listeners to reflect on the health promotion practice knowledge and challenges it reveals.

Some people feel unskilled or uncomfortable in writing their case stories. The Story-Dialogue Method should not exclude anyone because they lack writing skills or comfort. In these instances, people should be encouraged to speak their story into a tape-recorder, or to be interviewed by someone else who will tape-record their story. The tape-recorded story can then be transcribed into written form for use in the structured dialogue.

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Some Practical Tips

- Organizers of a Story-Dialogue meeting should give story-tellers plenty of time to prepare their stories (2 to 3 weeks notice)

- Story-tellers should review this entire Manual before they begin to prepare their story. Or organizers should copy sections of this Manual to prepare a shorter set of instructions for story-tellers.

- Follow-up phone reminders (encouragements) are often necessary.

- A meeting or conference call among the story-tellers can be helpful.

- All story-tellers should receive a short description of the theme(s) for the dialogue meeting.
CRAFT THE CASE STORY

When you are asked to contribute a case story for a Story-Dialogue session, you should follow these steps. Briefly outline your case story in writing or in point-form. Most case stories tend to be 3 to 5 pages in length (double-spaced). Some are shorter, others are longer. There is no "right" length for a case story.

Here are some other things to think about when you plan, then write your case story:

* A good case story is one that, relative to the generative theme:
  
  □ demonstrates “good” or “bad” health promotion practice, or a bit of both
  □ was particularly stimulating for you or others
  □ was particularly perplexing or difficult for you or others
  □ offers some beneficial lessons for you and your colleagues in other sectors

* Assume the others in your group know little or nothing about the social context in which your story exists. Describe:

  □ who was involved
  □ what actions you and others did
  □ when and where the actions took place
  □ what actions went smoothly
  □ what actions were difficult or puzzling

* Explain some of the reasons why you chose your actions

  □ why the particular health problem was chosen
  □ how your actions on this problem promoted better health
  □ how your organization’s structure and internal relationships affected what actions you chose
  □ how your organization (colleagues, superiors) and program or activity participants viewed your health promotion work (the feedback you received)

* Offer some reflections on your own story

  □ where there was consensus or disagreement about what should be done
  □ what you would do differently next time, and why
  □ what you would need to help you do it differently
It is helpful to focus your case story on one or two events when you encountered the theme or tension in your work. What was happening? What did you do? Why did you do it? So what did you learn from it?

Obviously, you will need to provide some context to the events to help story-listeners make sense of your experience. But case stories that attempt to tell the whole “story” of a program can lose the details by trying to describe the bigger picture. Learning in the Story-Dialogue Method intentionally builds up from the details.

**A Note on the “Theory” Behind the Story-Dialogue Method**

The Story-Dialogue Method is designed to lead health promoters and community members to a better and more generalized understanding of health promotion practice. Its building blocks are the details. Understanding the general arises from the particular through the structured dialogue process. This reverses the way people are usually taught in school or universities, where the general (theories, models) is used to inform the particular (practice strategies). Both forms of learning are valid and important.

"Formal Theory can validate . (It can be) useful for some reflection, critical thinking.*

*I go to a course (for theories, models) to get shocked out of my present thinking.*

"Some people know theories, but can’t practice, they don’t have the practical skills." Feather and Labonte, 1995

The Story-Dialogue Method brings theory and practice together by building theory from practice.
AN EXAMPLE CASE STORY

The case story that follows happens to deal with the generative theme of bureaucratic barriers (see Appendix 1). It is rich in description and therefore fairly long. Your written case story doesn’t have to be this long but you should be prepared to tell your case story with this level of detailed description. Plan on spending a few hours, perhaps longer, to prepare your story.

Example Story

Three years ago, the public health unit where I work applied for provincial funds to set up a community-based heart health program. There’d been a lot of recent announcements from governments about how heart disease was still the major cause of death, and how most of the risk factors could be prevented. Provincial funding would allow us to hire three new health education and health promotion staff for the heart health program. This program would also put us on the cutting edge, which our CEO wanted; usually mixed rural and suburban units such as ours receive little of the glory for innovative health promotion work.

The heart health program was to be collaborative, so I was asked to set up a project steering committee. Following suggestions from my colleagues in the public health unit I organized a meeting with members from the Heart and Stroke and Cancer Society local chapters, who were enthusiastic and readily provided names of others to sit on the committee. I also invited some health promoters from nearby Community Health Centres (CHC), who were more guarded, since most of their work was in organizing local anti-poverty, self-help and environmental action groups, or trying to stage community meetings and events on violence against women and children. Obviously, two different ways of thinking about health promotion were at work! However, one of the CHC health promoters did decide to join our committee, and all of them thought they could get their centres to endorse a grant application.

For our project, we decided on the neighbourhood where the CHC that wanted some active role in the project was located. We thought we could do some outreach and some health fair/awareness activities to mobilize a citizen committee. Our health unit data showed there was a slightly higher heart disease rate in the neighbourhood, and certainly the recent health promotion survey found more smoking, less fitness and poorer nutrition. Our goals were to improve individual lifestyles around these behaviours, as well as to tackle such things as public smoking policies, grocery store high fat food policies, school and other institutional cafeteria policies, and so on.

The project itself was slow in starting. It took some time for notification of the approval of our grant. Then we had to revise interest once funding was confirmed; hire staff (a recent PHN graduate, a graduate of a health education program, and a burned-out community worker looking for something less intense to do); develop plans and time-lines with specific deliverables for the funders; and hold the endless round of meetings which characterizes a collaborative process. As well, a number of racist incidents in the neighbourhood had diverted the attention of the community.

Continued...
Example Story (Continued) . . .

Because the CHC was participating in an outdoor neighbourhood festival, we decided to prepare a big display on heart health using the CHC as the “front.” We thought this would make it more attractive to local residents, as well as entice the health centre to become more interested again in the project. All the other agencies would be mentioned as sponsors, of course. There was a lot of politics involved, and I was also getting a bit of pressure from my managers and the project funders to “do something” and “show some results.”

The fair was successful, as far as the health unit and the project funders were concerned. About 350 people stopped by the heart health booth during the day, and we gave out at least 1,000 brochures and had 200 surveys completed on the spot. Also, ten local people volunteered to join our project committee - a success, I thought, since we had managed to generate some local interest. But I wasn’t so sure if the information/awareness approach was moving us forward very quickly.

Things began to change when the CHC decided somebody needed to begin organizing a new community group in a large public housing project experiencing serious racial violence, along with more usual drug, safety, welfare/poverty and unemployment problems. The CHC health promoter asked the heart health project team if they could use some of the staff resources (especially our community organizer) to help out. This is where we began to run into the bureaucratic problems with the health unit.

The managers were nervous for two reasons: first, the whole issue was too controversial and hot, and could explode on us creating a lot of bad press; and secondly, what does racism have to do with heart health? I convinced them that acting on underlying determinants could promote heart health, specifically, and overall health generally. However, they still wanted me to prepare a very precise plan, with measurable outcomes, that they could use to defend the expenditures to the local Board of Health.

The project steering committee was also concerned. The Heart and Stroke and Cancer Society representatives really didn’t understand the points I was trying to make. And everybody was nervous about the funders: would they think we were deviating too much from our original funding proposal? Meanwhile, the CHC representative was pressuring me pretty hard to take the risk and try something that seemed more relevant to the community. But how could we tie it into heart health?

After much discussion, the project staff decided to approach the steering committee and the CHC with the idea of organizing a big “Let’s Celebrate Diversity” picnic

Continued . . .
Example Story (Continued) . . .

Individuals from different ethnoracial backgrounds would be invited to prepare their favourite foods, and to plan some of their favourite party games or outdoor recreation activities. We could point out the nutritional or fitness aspects of the food and activities. The steering committee was still a bit nervous, but because we came with such a well-prepared argument and plan (and had managed to connect it to heart health) they agreed to give it a try. We all decided not to contact the funders, fearing they wouldn’t understand and that it would take too long trying to get them on side. In hindsight, this was a mistake. The resulting event attracted a lot of media attention, especially around the race relations theme, and the funders certainly did take notice. Because the event came off, they weren’t upset with what we had tried, but having been told in advance would have allowed them an opportunity to participate in the event (participation which, in the eyes of our community organizer, would have been a mixed blessing at best).

The organizing outreach work itself went pretty smoothly, largely because we had a staff member experienced in grassroots organizing, and two other staff young and eager enough to learn. In view of our theme of racism, I think the outreach would have benefited at the outset from staff who themselves were more representative of the ethnoracial mix in the neighbourhood who could have gained trust in the housing project even more easily. As it was, it took over 6 months of work to get a local neighbourhood group going that was able to plan and pull off the picnic event.

I confess that, as a health promotion program manager, I was out of my depth here. Nothing in my past (academic or career) had included the kind of door-knocking tenacity, “salespersonship” and on-the-spot trouble shooting that the community organizer engaged in. My role was primarily meeting organizer, note taker and meeting facilitator. As well, I was able to get a number of other local institutions on side: management in the housing project itself, which shared the same nervousness as my health unit; local churches (with big kitchens for food preparation); local food merchants (for donations of ingredients); and so on. While I thought it was my responsibility to initiate dialogue with these other organizations, my “best” health promotion practice was making sure that I mentored local residents along the way, making the connection but then disappearing so that the local residents had to maintain and use it for themselves.

The day-long picnic was definitely upbeat, with 400 people, a lot of good food and good games. We made sure that each ethnoracial cooking group, along with the health unit nutritionist, had a chance to describe their dishes, and their history. One of the Phys Ed teachers took participants through some warm-up and warm-down stretching before the activities that required physical exertion. No direct mention was made of heart healthy nutrition or physical fitness (and definitely no mention of smoking, which is still pretty high in the housing project, though none of the tables had ashtrays). Our staff spot-interviewed a number of the participants, asking them what they thought about the food, activities, theme, and the general feeling amongst all the different ethnoracial groups.

Continued . . .
Example Story (Continued) . . .

Today, about 20 people, including members of our target group, still actively participate in the organizing meetings. Right now a number of new project ideas are being talked about, including establishing some bulk food buying clubs, organizing "in the home" fitness breaks for single mothers, and a series of small experience-based workshops on race relations in the housing project.

We’re now two and half years into the three year project. Now the problem I face is: How do I prove to the funders that the CHC health fair and the picnic (the only two "hard outcomes") constitute a successful start? We seem poised for great things, and the project staff and project steering committee are keen. But we don’t have very much to show in the way of health behaviour change. This is where I need a lot of help!
CHAPTER 4

SHARING CASE STORIES: THE STRUCTURED DIALOGUE

The structured dialogue is how we create a deeper, shared understanding of the themes around which a case story is prepared. It is how we move from the particulars of peoples’ experiences to more generalized and useful knowledge about the themes.

A structured dialogue is different from a discussion or conversation. Discussions often ramble around topics in an informal way. No effort is made to find lessons in the story. The dialogue in the Story-Dialogue Method is intentionally structured, to allow the story-telling to:

* provide a detailed description of what happened;
* offer one or more explanations for what happened, and how it improved health or represented good health promotion practice;
* synthesize the key lessons from our stories; and
* plan new actions based upon our insights.

What drives the dialogue is our personal reflection on our own roles as health promoters in the case story’s events. This is why the case stories are written in the first person. The Story-Dialogue Method allows us to research (re-search, look once more at) our own experiences.

Some Practical Tips

Organizers of a Story-Dialogue meeting should familiarize themselves thoroughly with the Method.

Use Figure 1 to help describe the Story-Dialogue Method to persons who are unfamiliar with it.

Key points to be covered in this summary are:

* the re-emergence of the Importance of learning by stories;  

Continued
Some Practical Tips (Continued) . . .

- the many applications stories have in health promotion practice (see Chapter 7);
- why case stories are written in the first person (from the story-teller’s point of view);
- the generative themes selected for the stories, and how, why and by whom they were chosen;
- why a structured dialogue is important;
- the four question categories in the structured dialogue and what each is designed to do;
- instructions for the story-telling rounds

USE OPEN QUESTIONS

Open questions facilitate structured dialogue. They invite people to think about what the issue or concern (the generative theme) means in their health promotion work.

Open questions invite analysis and reflection. But what exactly do they look like? What’s the difference between open and closed questions?

Consider the following questions. Each of these questions has a different agenda or purpose behind it. The purpose is communicated in how the question is framed.

* Should we organize a community fair or petition the housing authorities? (A closed question offering limited choice of either/or. Closes off discussion of other alternatives. May reflect questioner’s own agenda.)

* Shouldn’t we be planning for the public meeting right now? (A closed question and an implied judgement—we should be planning for it. Not really a question at all; or what we often dismiss as a rhetorical question. Definitely reflects questioner’s agenda)

* How useful was our last meeting with the media? (An open question, asking us to evaluate a past action. Requires analysis and reflection.)
* Why did the chair of the committee become angry when we asked him what the annual budget for senior management salaries was? (An open question, asking us to explain an experience.)

* What do we think we should be doing a year from now? (Another open question, inviting us to understand better our own ideals, motives and goals.)

* What's the name of that woman who runs the drop-in centre down the street from here? (A specific closed question, demanding a focused and very precise response.)

* How can we improve our outreach work? (An open question, inviting a far-ranging discussion on a concern shared by all group members.)

* Do you think we should organize a community protest? (A closed question with a yes/no answer only. Prevents discussion of any alternatives.)

Open questions often begin with what, how and why; closed questions often begin with do, can and should. Open questions invite dialogue; closed questions shut off discussion. Open questions do not have correct answers; closed questions often imply expectations of a correct answer. Open questions invite a range of responses; closed questions limit choices. Closed questions seek a strategic decision, while open questions invite a dialogue about many possibilities. Open questions aim at better understanding.

**QUESTION CATEGORIES**

Four categories of open questions are used to generate the 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 experience? (Synthesis)

   This question invites us to summarize what we have learned from our practice experience.

4. **Now what** can we do about it? (Action)
A structured dialogue still has the dynamic ebb and flow of a conversation. It is not necessary to answer all the “What?” questions before proceeding to the “Why?” questions, then to the “So What?” questions, and so on. But it is important to ask all four types of questions.

**Some Practical Tips**

Organizers of a Story-Dialogue meeting who work to find the generative themes can use the questions in this Manual as examples for creating their own. Preparing a short list of example questions related directly to the theme (3 or 4 per question category) is often helpful. Before starting the dialogue, it is important that everyone:

- has an opportunity to reflect upon the questions;
- has an opportunity to jot down their own questions under the four categories;
- is reminded that the questions are guiding examples only;
- is cautioned not to ask the questions in a fixed order;
- is reminded to ask questions from all four categories, attending to the instructions offered by organizers or facilitators on when to move from one category to another.

The first two processes can happen when people at the Story-Dialogue meeting are briefed by organizers on the Method. The last three are good reminders for people just before they begin hearing the story/stories and engage in the structured dialogue.

**THE REFLECTION CIRCLE**

The reflection circle is designed to change the dialogue from an interview between the story-teller and story-listener to a shared dialogue that involves the whole group. It is an important step that grounds the dialogue in the experiences of the participants.

In a reflection circle, all story-listeners pause and reflect upon:

- How is the story I have just heard also my health promotion practice story?
- How are the issues in this story similar to or different from my own experience?

*Stories invite us to enter a dialogue with the teller. “This is my experience. How does it match with yours?” Talking Better Health, 1994*
The reflection circle should occur early in the structured dialogue. It works best immediately after the person finishes sharing the story.

The circle is a powerful method for building trust quickly. Going around in a circle, story-listeners in the group share what listening to the story triggered in them about their own practice. This should include feelings as well as thoughts. All of us have feelings about our work and it is as important to share these as it is to analyze our practices.

The general rules for sharing in a circle are:

* people speak one at a time;
* there is no response or dialogue between people in the circle until everyone has spoken;
* people can pass on speaking;
* speakers show their respect for one another by ensuring that their comments do not infringe on the time available for others to speak.

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**The Reflection Circle**

Participating in the dialogue may be difficult if our training has taught us that there are always right answers to questions or right ways to do certain things, such as plan programs.

Offering our reflections also requires trust in other people in the dialogue. The importance of developing trust among people using the Story-Dialogue Method is discussed later. Trust in groups builds over time, and many uses of the Method won’t provide much time to build it. There will always be an element of risk in sharing reflections. Organizers of a Story-Dialogue meeting need to acknowledge this, and encourage participants to practice generosity with one another. Generosity in this instance means accepting on faith that trust is there and, on the basis of this faith, create the trust.

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"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."

*University of Victoria, 1995*
THE DIALOGUE QUESTIONS

After the Reflection Circle, the dialogue begins. Below are examples of open questions in each of the four categories. These examples apply to many situations but they are given as guides only. Organizations and participants in a Story-Dialogue meeting should choose or create those questions most relevant to their own learning needs.

Description (What?) Questions

Most case stories begin by describing the story-teller's perceptions of what happened. Descriptive questions invite listeners to clarify details. They are equivalent to the journalist's technique of asking who, what, when, where and how? They help to ground the issue in real experiences.

Some of the questions posed at this stage include:

- What was the identified need, or problem or issue?
- Who identified it, that is, how did it arise?
- Who initiated the project or action?
- 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 the project?
- How did we do it?
- What were our successes?
- What were our problems?
- How were decisions made?
- How did we and others in the project relate to one another?
- How did it end? or What stage is it presently at?

With good preparation, story-tellers will probably answer most of these questions in their case story. During the structured dialogue, descriptive questions should be asked to help clarify the case story. But it is important that the dialogue not get stuck in descriptive questions. Health promoters need opportunities to describe their work and feel esteemed in their efforts. But because these are not the main goals of the Story-Dialogue Method, it is important to move past this stage in the dialogue.
The Forest and the Trees

Sometimes you can't see the forest for the trees
Sometimes you trip over a tree for looking only at the forest

The Story-Dialogue Method is used to create generalized knowledge and understanding using particular practice experiences. Learning begins by examining the details of the trees. But if we only look at the trees’ details we will never see or understand the grandeur of the larger forest ecosystem. We need both to see the trees, and to understand them in their relation to the forest. We need to move from describing the trees to explaining their effect on the forest, and explaining, in turn, how the forest as a whole affects the trees.

Explanation (Why?) Questions

Good explanation arises from good description. Explanation means offering an understandable and credible account for why things happened as they did. "Why?" questions invite a discussion on causes. This is where we begin to interpret or make sense of what has been described.

Some of the questions posed at this stage include:

* Why did we choose the project?
* Whose interests were most served by the way in which the problem or issue was named?
* Why did we do what we did (the strategies or actions)?
* Why do we think it promoted health?
* 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 organizational structures or relationships helped make the work successful?
* What did we find frustrating or disappointing about the project, and why?

A good explanation is not only logical and understandable. It is also the product of people talking with one another, questioning each other's perceptions and assumptions, reinforcing key insights while gently challenging others. A good explanation begins to uncover the different assumptions or theories people use in their work. Chapter 7 contains more information about
using the Story-Dialogue Method to develop health promotion theory that is grounded in practice experiences.

"There is nothing so practical as a good theory." attributed to sociologist, Kurt Lewin

"Oral testimony... produces "opinionated" material in the best sense of the word. However, it needs to be recognized as such. One person's testimony represents one particular perspective and not an overview. Much "information" is likely to be within the realms of conviction and belief rather than undisputed evidence, and many apparently factual statements will in reality represent people's judgements on an issue." Slim and Thompson, 1995

How do we know that our explanations accurately reflect what happened, or offer the best understanding? An explanation is valid when it reflects what actually happened, and not just what practitioners wanted to see happen. This is what is meant by the term "rigour," and why the Story-Dialogue Method emphasizes the rigorous use of stories.

Only if we ask these "Why?" questions can we move beyond the particulars of the problems we face in our work to what is more characteristic or generalizable about the situation. "Why?" questions allow us to see both the trees and the forest.

How or Why Questions?

"Why?" is a question with different faces. When we are young, we often pester those older than us with "why?" questions, seeking to know the reasons behind what we see. "Why?" shows a joyful and healthy curiosity about our experiences in the world. This is the spirit in which the "Why?" questions should be posed in the structured dialogue.

As we grow older, that joy often becomes defensiveness when those with more power demand that we account for our actions. "Why did you do that?" usually means that what you did was wrong. The spirit of the question has become judgemental, rather than inquiring.

Continued...
How or Why Questions? (Continued) . . .

"How?" questions can soften the judgemental edge of "why?" and take us to the same explanatory level of understanding. Instead of asking, "Why did we choose the project?" we can ask, "How did we come to choose the project?" Instead of asking, "Why do we think it promoted health?" we can ask, "How did it promote health?" The choice of phrasing the question is yours. But remember that the purpose of the questions is to prompt us to make a credible explanatory account of our work.

Synthesis (So What?) Questions

Once we are reasonably sure that our explanation is a good one (it is understandable and credible), we need to spend some time synthesizing or drawing together what was learned from the experience.

Some of the questions posed at this stage include:

* What have we learned, as practitioners (about practice)?
* What remains confusing about our practice?
* What have we learned, as "communities" (about health promotion outcomes)?
* How have people changed through the process?
* How have organizations changed through the process?
* How did relationships between people and organizations change in the project?
* What were the unexpected spin-offs?

The purpose of this stage in the dialogue is to tease from the story what are more generalizable lessons about health promotion practice. What new knowledge about practice, about health, about health promotion, about communities and the process of community change have we acquired?

Case stories are built upon one detailed practice example. It is hard to generalize from one example to other situations. But it is a questionable use of resources to plan and implement a project, or to develop a case story about the project shared in a Story-Dialogue meeting, without making some effort to indicate what might relate to other practitioners.

"The element of subjective opinion (in story-telling) should always be recognized. If not, there is the risk that the general is extrapolated from the particular when this is inappropriate." Slim and Thompson, 1995
Action (Now What?) Questions

The purpose of the Story-Dialogue Method is to help health promoters and those in communities with whom they work to plan new and more effective actions.

Some of the questions at this stage include:

* 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?

This level of questioning translates what we think was significant about the case story into new actions. This is the stage of action planning.

A Word of Caution About the Story-Dialogue Method

Some people find the structure of the dialogue too confining. Others find it essential to their learning. Many find it awkward at first.

The Story-Dialogue Method is a tool. Like any tool, we should use it if we find it helpful to the task, adapt it if it doesn’t quite fit and feel free to invent new uses for it. As with any tool, it takes practice to learn how to use it most effectively for the work at hand.

"The structured dialogue seemed awkward at first. But we needed it. Without it, we would never have dug deeper into our stories." University of Victoria, 1995

"I work on a native reserve, and story-telling is part of the process but there are no papers (Insight Cards). Story-telling is the greatest learning tool we could ever have. I’d like to organize it less." Feather and Labonte, 1995
STORY GROUP ROLES IN THE STRUCTURED DIALOGUE

Case stories are usually shared in small groups, which this Manual calls story groups. They can also be shared before a larger plenary group, but the structured dialogue should only occur in a story group. These groups might number as few as three persons, or as many as eight to twelve. If the story group becomes larger than twelve to fifteen in number, its dynamics shift in ways that make full participation in the dialogue by all members more difficult. Many small group researchers recommend an ideal group size between five and seven.

Regardless of how small or large the story groups, there are four principal roles participants play in the structured dialogue: they may be story-tellers, story-listeners, story-recorders, or facilitators.

Sometimes each member in the story group will take turns being a story-teller and a story-listener. The roles of story-recorders and facilitators also can be shared among story-listeners. But it helps if a facilitator briefed on the Method or experienced with its use is also present to help the process along.

Here are some hints about fulfilling these different roles:

**Story-Teller**

Tell your story to your listener(s). You could read your prepared story, or use the written story as an aid and expand upon it as you go along. Be sure to pay attention to the points above about crafting the story in advance. Beware of using buzzwords or catch phrases in your story; clearly spell out your ideas so everyone can understand you.

"What helped is that the stories weren't just gritty, or self-congratulatory, but tried to dig beneath the surface." University of Victoria, 1996

**Story-Listener**

At first, you will be an active listener, perhaps making a few brief notes about things that you hear that spark your interest or raise more questions than they answer. Try very hard as you listen to imagine the story from the story-teller's point of view. You will hear the story through the filters of your own experience, finding connections with the story-teller's experience, perhaps even some "Ah! Hahs!" about practice. This is important. But wait

"Have you ever wondered why you have one mouth and two ears? Because it is much easier to talk than it is to listen." Asian proverb
until the whole story is finished before you begin to reflect on these thoughts. If you try to make these connections while the story is still being told, you will stop hearing it from the story-teller’s point of view. The point here is to **listen**.

After the story is finished, it becomes important to collect your reflections on what it was like to hear the story and how the story connects to your own work experiences. This helps to ground the story in a larger body of experiences. This is the purpose behind the reflection circle.

After the reflection circle, scan the list of reflective questions, selecting a few to use to begin the dialogue. It doesn’t matter in what order you use the questions. Just be sure that you pose questions from all of the categories. Organizers and facilitators can help you to keep moving through the categories of questions in the time allowed for your dialogue.

Finally, you are not an interviewer. The dialogue is still a conversation, even though it is structured around prompting questions.

**Facilitator**

Your role is to make sure that:

* everyone agrees to the norms of caring, being critical and respecting the confidence of the group (see Chapter 5);

* the reflection circle occurs;

* the structured dialogue keeps on time;

* the structured dialogue works its way through all of the question categories;

* everyone has an opportunity to participate to the extent they wish to;

* the structured dialogue does not become a group interview of the story-teller; story-listeners also question each other on what they shared in the reflection circle;

* discussion does not bog down in description and problem-solving of the particular case story;

* discussion does not get short-circuited by jargon or buzzwords.
Everyone in the story group can assume these responsibilities. But it also helps for each story group to have a facilitator more familiar with the Method.

Facilitators are also story-listeners.

*Story-Recorder*

In many uses of the Story-Dialogue Method, recording insights that come from the structured dialogue is important. As a story-recorder, you will make notes about the structured dialogue on worksheets designed for the different question categories. Different people can take responsibility for different categories of questions, making four story-recorders in total. At a designated time in the dialogue, you will briefly review your notes with the rest of the story group to ensure that they are an accurate representation. These notes become the basis for synthesizing new knowledge about practice.

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<thead>
<tr>
<th>Some Practical Tips</th>
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<tbody>
<tr>
<td>Story groups participatibg in a Story-Dialogue meeting might agree to have their dialogues tape-recorded. Transcripts of these tape-recordings can be studied with even greater rigour using qualitative methods; that kind of analysis requires experience and skill in qualitative research.</td>
</tr>
<tr>
<td>If the Story-Dialogue Method is used for this form of research:</td>
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<tr>
<td>• notice of the intent should be shared with participants well in advance;</td>
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<tr>
<td>• consent from all participants should be given in writing;</td>
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<tr>
<td>• results of the researcher’s work should be shared with any interested participants at a later meeting, so that participants can express their views on how the researcher interpreted the dialogue information</td>
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Notes on the structured dialogue are not word-for-word, but they do need enough point-form detail that they make sense to both you and the story group when the time comes for you to share them.

* Notes on “What?” questions summarize any direct responses to “What?” questions. Otherwise, include only those parts of the dialogue that are additional to the actual story. Don’t try to rewrite what the story-teller shares orally.
* Notes on "Why?" questions summarize any direct responses to "Why?" or "How?" questions. Otherwise, listen for when people appear to be explaining something.

* Notes on "So What?" questions summarize what people offer or conclude about health promotion practice.

* Notes on "Now What?" summarize what people say about how things might be done differently.

_Some Practical Tips_

Use different coloured paper for different question categories. The colour should be pale so that the written notes stand out.

Make sure you have enough Question Category Record Sheets. Plan to use 2 for each Question Category, times the number of stories that will be shared.
CHAPTER 5

CREATING TRUST IN SHARING CASE STORIES

Because case stories are about us -- about our experiences and the meaning we have tried to make of them -- all uses of the Method share two things in common:

* case stories are shared in small groups;
* sharing stories involves risk-taking and vulnerability.

Trust takes time to build. When the Story-Dialogue Method is part of a longer training program or part of regular peer group or project team meetings, trust-building exercises can be used alongside the Method. But there may be times when the Story-Dialogue Method is used with people who don't know one another well, under time constraints that limit the ability to build trust in the group. As well, trust and safety are important considerations when the group includes people from different levels in the same or similar organizations (for example, program directors or supervisors, and field level staff or volunteers).

Finally, it takes a lot of trust for a story-teller to honestly recount experiences that reveal uncertainty, tensions or conflicts in practice.

There are steps organizers and participants can take to minimize the risk and maximize the trust. One of these is using the reflection circle. Here are some other suggestions:

1. Use facilitators in the small groups, and train or brief them before the Story-Dialogue meeting.

2. Ensure that people who come to the meeting have a clear idea of its purpose and its process. The key messages to convey are:

   * People will be sharing their own experiences in order to learn more about practice.

   * People will be engaging respectfully, yet critically, in a dialogue with each other about these experiences.
People will not be provided with specific "how to" lectures about practice. They will be learning from each other's experiences.

Because the Story-Dialogue Method is experience-based learning and research, all participants should have some experience in practice.

3. Avoid inviting too large a group. Even though story-telling and dialogue takes place in smaller groups, a larger plenary group can make sharing between small groups more threatening and logistically more difficult. Experience with the Method suggests a maximum of between 50 and 100 persons, and an ideal of between 25 and 40.

4. Set norms for the meeting. Apart from general small group norms concerning the importance of listening, experience with the Method underscores the importance of agreement on the following points:

We Will Be Critical, asking and answering probing questions about our work in order to do it better. But we will not criticize, or cast blame on persons.

We Will Be Caring, to ensure that our questions and our answers are generated in a climate of respect for the values that motivate us in our work and for the skills and knowledge we already possess.

We Will Be Careful, respecting the confidences of those story-tellers who are taking the risks to share their experiences. But we accept the responsibility to share with others what we might learn about practice in a more generalized sense.

It is helpful for organizers to state these norms at the outset of a Story-Dialogue meeting, and to include them in any publicity about the meeting. It is also helpful for small group facilitators to remind story-tellers and story-listeners of these commitments to one another before the small groups begin their work.

If care is taken on these points, sources of conflict or risk can be minimized.

But conflict and risk are not completely unavoidable. Nor should they be. The possibility of conflict and emotionally expressed difference shouldn't prevent the use of case stories. But it is a possibility of which organizers, group facilitators and participants need to be aware.
"I think we're sometimes too polite with each other. We back off from the hard questions, from the disagreements."
Project Team, 1995

Finally, participants in Story-Dialogue meetings are likely to ask for copies of each other’s stories. Permission from the story-tellers to distribute their stories is a must. Sometimes story-tellers may wish to re-write their story for a more public distribution, to avoid conflicts at work. Sometimes groups agree to exchange stories only if all promise to keep the stories confidential to themselves.

At all times, the fact that these are personal case stories must be reinforced among all participants. Other people involved may read a case story that has been distributed and disagree with its contents. This is OK.

When practitioners share case stories with one another, the stories are told from a single point of view. The structured dialogue in this instance is not concerned with reaching consensus on how accurately the story reflects differing points of view. It is concerned with reaching consensus between story-tellers and story-listeners on useful, general lessons about health promotion practice. When case stories are distributed publically, this distinction should be noted.

When case stories are “worked up” to become case studies (see Chapter 7 for more about case studies), these points of disagreement become some of the tensions or generative themes around which people create additional case stories and dialogue further. In a case study, some consensus on the validity of the case stories that inform it needs to be reached.
CHAPTER 6

CREATING INSIGHT CARDS

When the Story-Dialogue Method is used for team-building or for problem-solving during a peer group meeting, generating a written record of the dialogue may not always be important. A verbal review of the story-recorders’ notes, followed by more dialogue around the particular case story, may be sufficient.

In most other uses of the Method (knowledge development, evaluation, research or planning) recording insights for further reflection is very important. In these uses, participants will be listening to and discussing two or more case stories on the same theme. They are attempting a second level synthesis (see below, page 53) about what is similar or different in the practice insights generated by particular stories.

The technique used to capture these insights is creating Insight Cards. Because many small group learning and planning processes use a similar card technique, there is a good chance that many people in a Story-Dialogue meeting will have some experience with its basics.

After each case story has been discussed in a structured dialogue, story-recorders share their notes with the whole story group. Using Insight Card sheets, each story group creates 2 to 4 Insight Cards for each of the four categories of questions, or about 8 to 16 Insights Cards in total. The story groups should not feel compelled to create more insights than the group thinks are warranted. Some question categories (e.g. “Why?” “So What?”) may generate more insights than other categories. The point is to have enough insights from each case story that a later comparison between different case stories (the second level synthesis) can be more revealing.

Insights could be “Ah! Hahs!” that people in the story group experienced. They could be particular lessons or tips about practice that were offered. They could also be questions, puzzles or challenges that remain. The only criteria for an insight are that it represents something that is important in practice, and that it is worth sharing with other people beyond the story group.

Each insight should be written clearly on a separate sheet, and should have enough detail that it is understandable to someone who was not a part of the story group. Below are some examples of “bad” and “good” Insight Cards. The first set of examples are based on the Example Story (see page 18). The second set of examples are based on stories told by people in the field of education, around the theme of developing effective partnerships for organizational health.
Example 1: Insights Cards about the Example Story

Examples from What? Category

BAD example: Facilitator
GOOD example: My role primarily "mentoring" groups in connecting them to resources

Examples from Why? Category

BAD example: Respond to community
GOOD example: Able to reframe community group issues in heart health "language," therefore increasing their resources

Examples from So What? Category

BAD example: Politics drives local health issues
GOOD example: My practice, my institution needs to be more flexible in our programs because community issues are dynamic, often change

Examples from Now What? Category - lesson learned

BAD example: Need to collaborate
GOOD example: Different stakeholders view same issue differently; I need to give more support to how less powerful view the issue

Examples from Now What? Category - still puzzling

BAD example: Funders don’t understand CD
GOOD example: Need ways to document progress, process and "successes" in CD work.

Example 2: Insights Cards about Stories on Creating Effective Partnerships for Organizational Health

Examples from What? Category

BAD example: Facilitator
GOOD example: My role primarily surfacing and facilitating discussion of "hidden agendas" between partners

Continued
Example 2: *Insight Cards about Stories on Creating Effective Partnerships for Organizational Health (Continued)...*

**Examples from Why? Category**

BAD example: Overcome competing agendas  
GOOD example: Able to reframe different partners’ agendas in common language, creating new goals for partnership that all partners “own”

**Examples from So What? Category**

BAD example: Personal issues drive the partnership.  
GOOD example: Need good listening/facilitating skills to ensure that personal issues don’t get in the way of organizational relations between partners

**Examples from Now What? Category - lesson learned**

BAD example: Need more collaboration  
GOOD example: Powerful partners’ views on issues often dominate; need to pay more attention to views of less powerful partners

**Examples from Now What? Category - still puzzling**

BAD example: System doesn’t value partnerships  
GOOD example: Need ways to document progress, process and outcomes of successful partnership work

These examples show that a good Insight Card gives more detail about what was discussed and synthesized. It avoids use of buzzwords or cliches. The examples also show that different generative themes (bureaucratic barriers, and creating effective partnerships) often generate similar practice insights (more about the implications of that below).
**Some Practical Tips**

Organizers and facilitators should:

- Explain how GOOD Insight Cards are created;
- Provide story group participants with examples of GOOD and BAD Insight Cards to illustrate the distinction;
- Explain the purposes for creating these Cards.

Many participants at the beginning of a Story-Dialogue meeting may be confused enough with the structured dialogue technique. Instructions for the Insight Cards should not be given at the same time as instructions for the structured dialogue. Instead, pull all of the story groups together and provide Insight Card instructions when they reach this point of their process during the first round of story-telling and dialogue.

Usually, the Story-Dialogue Method involves several rounds of story-telling. In these cases it is helpful for organizers to examine some of the Insight Cards generated after the first story round and to use them to provide advice on how such Cards might be improved during later rounds.

**Better Insight Cards**

A sample of Insight Cards from the first round of stories at the University of Toronto Health Promotion Summer School were selected by organizers with the permission of the story groups that created them. Information on the Cards was transferred to overheads and shared with the larger plenary group, alongside additional comments from the organizers.

The column starting at the left margin shows the Insight Card as it was written. The indented sections indicate what organizers thought would be a better way to write the Card, and some of the second level synthesis questions the Card might generate.

**What? Question Category**

**Original Wording**

- Partnership
- * Lung Association
- * Employees
- * PHNs
- * Management
- * Union

**Continued...**
Better Insight Cards (Continued) . . .

Suggested Changes

Identified and developed partnerships, key stakeholders

**Second level synthesis**: Why are partnerships important? What criteria do we use to identify “key” stakeholders? How/why/when do we involve such stakeholders?

Original Wording

Decisions
* Collaborative
* Consensus
* Facilitated

Suggested Changes

Used facilitator to negotiate consensus approach to decision-making

**Second level synthesis**: Why a facilitator? Possible reason: We need non-vested outsiders in potentially conflictual situation.

Why? Question Category

Original Wording

Based on previous experience

Suggested Changes

Need to begin with activities within (participants’? project staff’s? specify who is the subject) experiences.

**Second level synthesis**: Why is it necessary to keep activities within peoples’ experience? How/when is it useful to move beyond past experience in order for new learning and actions to arise?

Original Wording

The less you do, the more you achieve

Suggested Changes

Professionals need to avoid doing everything in order to free up energies of other participants in project

Continued . . .
Better Insight Cards (Continued) . . .

**Second level synthesis**: When is this appropriate? How is this done? How do power relations shift in this process?

**So What? Question Category**

**Original Wording**
Different perspective from different partners

**Suggested Changes**
Different members' perspectives need to be talked through to consensus for action to occur

**Second level synthesis**: When is such consensus necessary? When is conflict "healthier" than consensus? How can a single perspective be formed that doesn't feel imposed on different partners?

**Original Wording**
Shit happens

**Suggested Changes**
There are external powers beyond project control; need to take more account of these in planning, evaluation

**Second level synthesis**: How are these powers identified? How can they be managed or co-opted?

**Original Wording**
Cover your ass

**Suggested Changes**
Need to build legitimacy for potentially controversial actions before taking them

**Second level synthesis**: What legitimacy is needed? Specific policies? Sympathetic managers? Other legitimating strategies?

Continued . . .
**Better Insight Cards (Continued) . . .**

**Now What? Question Category**

*Original Wording*

Be authentic

*Suggested Changes*

Share our professional power, expertise and privilege in non-patronizing way

*Second level synthesis:* What do we need for such sharing? How can having a personal (not just professional) stake in issue we're working on help in this process?

*Original Wording*

Share success

*Suggested Changes*

Determine what resources we can place under more control of groups we work with

*Second level synthesis:* What are our resources? Which resources do community groups find most helpful?

*Original Wording*

Encourage community ownership

*Suggested Changes*

Ensure community has decision making authority in project

*Second level synthesis:* Who is community? How much authority should they have and why? What is ownership? (self-sufficient, independent, able to negotiate for resources with more powerful social groups?)

Finally, after Insight Cards are created, they are posted on a wall in clusters headed by the four question categories: What? Why? So What? Now What?

What you do with the Insight Cards from this point on, depends on the purpose of the Story-Dialogue meeting. Uses of the Method, and related uses of the Insight Cards, are discussed in Chapter 7.
**Some Practical Tips**

Insight Cards can be on paper ranging from 5" x 7" to 8 1/2" x 11". Experience has found that the larger size works better.

Insight Cards should be written with broad-tipped, dark coloured, non-toxic (water-based) markers.

Insight Cards are generated for each question category. Use the same colour paper that story-recorders used for each question category (e.g. pale blue for "What?" story-recorder notes, pale blue for "What?" Insight Cards).

Insight Cards can be posted on the wall using a non-permanent adhesive (e.g. Fun-tac).

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**TIMING THE ENTIRE STORY-DIALOGUE METHOD**

Each round of story-telling and structured dialogue takes a minimum of an hour. A sample structure for one round of story-telling might look something like this (all times are approximate):

- Tell the story: 5 to 10 minutes
- Reflection circle: 10 minutes
- Structured dialogue: 25 to 45 minutes
- Review story-records: 5 minutes
- Create Insight Cards: 15 to 20 minutes
- Total time for round: 60 to 90 minutes

Times can be adjusted depending on:

- how many stories will be shared in each story group;
- how much second level synthesis will be done with the Insight Cards;
- how much time is available for the whole meeting.

Some people using the Story-Dialogue Method think that there should be more relaxed time in the structured dialogue. Other people think that too much time in the structured dialogue would cause it to "unstructure" and become a less productive exercise. Allow a minimum of 60 and a maximum of 90 minutes for each story and structured dialogue. Adjust with experience.
Some Practical Tips

Organizers or story group facilitators should allocate certain times for each question category during the period of the structured dialogue itself. Experience has found the following times helpful:

- What? questions: 5 to 10 minutes
- Why? questions: 10 to 15 minutes
- So What? questions: 5 to 10 minutes
- Now What? questions: 5 to 10 minutes
- Total structured dialogue: 25 to 45 minutes

An organizer who is not participating in a story group can keep all of the story groups moving along by announcing 5 to 10 minutes after the structured dialogue begins, "It's time to move on to Why? questions if you haven't already started..."; and 10 to 15 minutes later, "It's time to move on to So What? questions if you haven't already started..."; and so on.

"At first I found the organizer telling us when to move from one category of questions to another annoying. Afterwards I realized how necessary it was to keep us from getting stuck in a rut." University of Victoria, 1995

Just before story-records are reviewed, organizers should provide all story groups with instructions on creating Insight Cards. If this is not possible with the large group, facilitators of each story group should provide the instructions. Attention can be drawn to the examples in this Manual. These instructions will add 5 to 10 minutes to the first round of story-telling.
PART II:

USING THE METHOD
CHAPTER 7

USING THE STORY-DIALOGUE METHOD

This Chapter describes several applications of the Story-Dialogue Method. In the work that led up to this Manual, most of these applications have been tested. Some of the uses are still just ideas that need testing. Most people who took part in the Story-Dialogue meetings were excited about the possibilities of using it in various projects. In this chapter, the many potential uses are grouped under the following headings: problem-solving and program planning; knowledge development; and case study evaluation.

Some Practical Tips

- Before organizing a Story-Dialogue meeting, be clear on the purpose.
- Communicate this purpose to all participants.

USING CASE STORIES FOR PROBLEM-SOLVING AND PLANNING

The Single Case Story Analysis

The Story-Dialogue Method can be used to solve problems around a single case story. The story group is made up of people doing similar work to the story-teller. The process is fairly informal, although the structured dialogue and Insight Cards should be used, to ensure that the process leads to “Now What?” action plans that address:

- the story-teller’s immediate concerns;
- concerns of other persons involved in the case;
- concerns related to the story-teller’s workplace organization;
- concerns that may be more generalized for similar practitioners, or similar cases.
Using Case Stories in Staff Meetings

A variation of using the Method on a single case is to apply it across several cases. Comparing insights across different cases can enrich participants' learning and develop more generalized lessons about practice. The story group becomes the staff group and the Story-Dialogue Method becomes part of regularly scheduled staff meetings. If the group is too large (more than 12 or 15 staff), two or more story groups can form.

Individual workers offer to develop a case story from their practice. Practice diaries or logs are common to many disciplines, and can form the basis for case stories. A minimum of two stories should be shared in each story group, bearing in mind that each story round (story, structured dialogue, Insight Cards) takes between 60 and 90 minutes.

Insight Cards should always be used when two or more stories are examined (i.e. a second level synthesis is desired).

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"Most of our staff meetings are consumed by issues about administrative support, photocopiers and long-distance phone calls. We don't spend enough time talking about our practice problems!" Project Team, 1995
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Some Practical Tips

Instructions for a second level synthesis are given in the section on knowledge development later in this Chapter.

Some of the steps in this second level synthesis (e.g. written theory notes) can be eliminated if the purpose of sharing several case stories is primarily to help the story-tellers to solve particular practice concerns they are facing.

If the staff group is comprised of peers (people working at the same organizational level), the generative themes likely will relate to concerns they have in their practice with individuals and groups in the larger community. Case stories can explore questions around these practice concerns.

If the staff group includes people working at different organizational levels (front-line staff, supervisors, managers and so on), the generative themes may include concerns that are specific to relations and policies within the organization. Case stories can explore questions about these relations. In this situation, it is important to ensure that all participants feel safe as they share
experiences and insights (See Chapter 5).

In an alternate approach to case stories within a single organization, the staff selects a particularly troublesome case or situation. People at different levels of the organization prepare case stories around this case, focusing on problems or issues that relate directly to their position in the agency. Insight Cards can be written in different colour markers to correspond to case stories from the different organizational levels. This can allow staff to examine what is similar or dissimilar for practitioners who may be front-line workers or senior managers. “So What?” questions can focus on what staff have learned about their colleagues’ work, the demands on them, and their styles of practice. “Now What?” questions can focus on what people need from each other, across the organizational levels, to respond better to the challenges raised by the case.

Sharing stories around the same case from multiple points of view also helps in team-building. It enables all staff to understand better how issues differ for people at different organizational levels.

Using Case Stories in Program Planning

Program planning represents the “Now What?” stage of the structured dialogue. Some decisions about next steps should always be made when using the Story-Discourse Method. Case stories also can help to frame the issues around which planning should be done. The Story-Discourse Method is not another program planning method. Rather, it complements program planning.

An Example of Using Case Stories in Program Planning

A District Health Council (DHC), a provincially mandated health planning body, was asked to prepare a regional health promotion plan. Midway in the process, health promoters from key stakeholder sectors were brought together in a Story-Discourse workshop. They spent the morning sharing case stories about practice tensions identified by the planning committee, based on its prior consultations with these sectors. Each sector shared a case story in groups that included representatives from all of the different sectors. The purpose was to improve intersectoral understanding, and to clarify some of the operational distinctions different sectors gave to the concept of health promotion.

In the afternoon, two case stories on intersectoral collaboration were shared in plenary. As a generative theme, organizers identified a tension they expressed as follows: "fiscal restraint might foster collaboration (doing more with less), but it could also lead to doing
An Example of Using Case Stories in Program Planning (Continued) . . .

less with less.” The theme, like the morning’s practice tensions, was culled from reports on prior consultations and surveys.

In small groups, people first reflected on their own experiences with the collaboration tension, then discussed three focus questions:

1. What do we need to share with each other to do better health promotion/ disease prevention work?
2. How can we share these things more effectively; that is, what steps can we take with each other, right now?
3. What outside enabling do we need (and from whom) to allow us to share these things more effectively?

Their conclusions were synthesized on Insight Cards and posted on the wall. In plenary, facilitators quickly summarized the Cards’ comments as they applied to the DHC role. This summary led into small group discussions about the specific roles the DHC should play to enable better health promotion practice by and among key stakeholders. The information obtained during the day was incorporated into the committee’s planning work.

USING CASE STORIES FOR KNOWLEDGE DEVELOPMENT

Most use of the Story-Dialogue Method has been to develop better health promotion practice knowledge. Health promoters from many organizations and different organizational levels come together to share stories related to one generative theme. If a small number of practitioners are involved, all persons can take turns telling their stories in story groups.

Some Practical Tips

Because each story round takes between 60 and 90 minutes, no more than three stories can be shared in a single morning or afternoon session.

It is helpful to have more than these three story-tellers in a single story group. If 5 or 6 people form a story group, the task of story-recording becomes easier and the dialogue around the stories is richer.

If all participants have stories to share, story groups can be organized in groups of six. Three persons share their stories in the morning. Three persons share their stories in the afternoon. Everyone not telling a story becomes a story-listener and/or story-recorder.

Continued . . .
Some Practical Tips (Continued) . . .

Everyone participates in the structured dialogue and creation of Insight Cards. A second half-day should be planned for story groups to return to their Insight Cards for a second-level synthesis.

Decisions about how many stories to share and how to structure the story-telling rounds always depend on the amount of time available for the Story-Dialogue meeting.

When participants share many case stories in order to develop their own knowledge, they engage in a second level of synthesis using Insight Cards.

A Second Level Synthesis

Case stories are also sometimes called narratives. We try to understand our world better by writing it, or by drawing it, or simply by speaking it. Once it is external to us, we can look at it "as a whole" for important insights that might guide us in making decisions. When we analyze insights from different experiences or case stories around the same issue, we are better able to make connections between the experiences and to develop guidelines for the future. In other words, we synthesize lessons and to develop practice generalizations. There are three steps involved in a second level synthesis: building categories from the Insight Cards; writing theory notes based on the categories; and sharing the theory notes with participants from other story groups.

Some Practical Tips

Allow between 30 and 60 minutes for building categories, 30 minutes for writing theory notes and 30 minutes for sharing theory notes in a plenary. Allow additional time to give instructions to participants about the steps involved.

It is helpful to involve a qualitative researcher in a Story-Dialogue meeting that uses a second level synthesis. These researchers are familiar with the techniques involved in building categories and writing theory notes.

If it is not possible to involve a qualitative researcher, organizers might seek advice from one before undertaking a second level synthesis.
Building Categories

Categories group together similar ideas from a range of insights. Sometimes this process is called finding common themes. 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.” Some describe it as a free act of “seeing” meaning.

Practitioners? or Researchers?

The Story-Dialogue Method is not intended to transform practitioners into researchers. But it is a tool that uses some of the rigour of qualitative research methods to help practitioners increase the validity and generalizability of usefulness of the insights they glean from their own practice experiences.

There is nothing so theoretical as a good practice!

Some qualitative researchers form categories working alone, but the process also works well with groups. When we make Insight Cards, we are operating with largely unconscious assumptions about how or why things fit together. These assumptions are our unconscious and taken-for-granted theories of health promotion practice. By moving the Cards around into categories, we make these theories of practice more conscious. We are also making them more public in a group situation. This gives us an opportunity to become critical about our theories. We become better at explaining why we do what we do, and through this process, arrive at more general lessons for practice.

Some Practical Tips

Making categories often comes easy to most people. A few things to think about:

- Lunch or a good night’s sleep usually comes between creating Insight Cards and doing a second level synthesis. Ensure when you re-examine the Cards that you understand what your story group meant when they wrote them. Take the time to elaborate on Cards whose meanings are uncertain.

- Look behind the actual words at the ideas they represent. Don’t assume that categories can be built around the use of the same word or phrase.

Continued...
Some Practical Tips (Continued) . . .

- Use the Cards as memory aids that take you back to the stories and the structured dialogues that generated them. As you create categories, you may have to add details from the original story to the Cards. Feel free to create new Cards if it helps you and your story group to understand the larger context of the wall-map of Cards you have created.

- Look for similarities or patterns, Insight Card statements that seem to be the same. Put them alongside one another. At this point, it doesn’t matter which Question Categories the Insight Cards were originally placed in. Move them between Question Categories if it helps in your understanding of the Cards’ contents. As clusters of Cards are grouped together, ask some “what?” “why?” and “so what?” questions about what you see:
  - What do we see?
  - Why do we think these statements belong together?
  - So what does placing them together tell us about our practice?

- Sometimes Cards concern the same issue but say contradictory things about it. This can help to deepen an understanding of what’s going on. How can we explain what’s going on in a way that uses both statements?

- Sometimes the same Card fits in many categories. If there’s a good reason for this, copy the Card and place it in several categories. But the reason should be a good one. Otherwise the categories will start to resemble one another.

- Look for different statements that seem to relate to the same underlying issue. These statements may help us explain a more complex chain of practice actions, because there seems to be some step-wise relation between them. This allows us to ask: Why do we go through these steps in our work?

- It helps if only one or two people at a time are involved in moving Cards around into categories. One person can assume responsibility for the whole process. Story group participants can also share the task, suggesting and physically creating a category when one “emerges” for them.

"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." University of Victoria, 1995

The last step in the process is to give the category a name. Because these categories are about our practice, their names should say something about our practice. Is it a skill? A power relation or struggle? An attitude or ethical “should do...” about our work? The name should represent the “glue” that binds together all of the Cards in the category.
Making Theory Notes

Theory is simply a logical and understandable statement of what we do, why we do it and why it leads us to where we want to go, which, in the case of health promotion, is to improve the health or well-being of people. University of Toronto, 1995

After the categories have been made, story groups write up a descriptive statement that links all the different parts together. This description is called a theory note.

A theory note describes the Insight Cards placed within a single category, and combines the ideas into a single statement. Other practitioners who were not part of your story group would probably not understand what your category means just by looking at the Cards. Your theory note is an attempt to explain what you think can be generalized from the category. Theory notes are statements about health promotion practice.

Theory as Argument

A theory note is like an argument, a claim about “what is” that is both understandable and credible to others. George Lakoff and Mark Johnson, two philosophers of language, in their book Metaphors We Live By, argue that we organize our knowledge by using metaphors. One of the examples they give is that of “argument.” An argument, they say, is like a journey. It has a beginning and an end. It has a path that we travel along forward in time. The path is a surface. It has boundaries. There are some things that are “outside” our argument (our path) and some things that are “inside.” An argument is not about everything all at once, any more than a path takes us everywhere we want to go. An argument, like a path, narrows our vision of where we are going in order to understand better the particular path we are on. Journeys end. Arguments also reach a conclusion. But just as the end of one journey marks the start of another, an argument does not have to reach a “final point.” It simply reaches a point where that particular path seems to end. Then we can begin to explore other paths with what we have learned by exploring the one we just left.

Here are some tips about building a theory note:

1. Look for the starting point for the theory note. This will be a Card, or cluster of Cards, that seem more basic than the others. It may be more basic in the sense of time. If you don’t start there, the rest of the Cards won’t make sense. It could also be more basic because it “anchors” or links together all of the other Cards.
2. Look for the temporal sequence. If you were to explain the Cards in the category to someone else, how would you organize the explanation? This ordering by time represents the steps you take along the practice path represented by your category.

3. Look for the gaps between the steps. Are they small enough that progress from one step to another is clear? Or do you need to add more to the category and the Cards to ensure that the notes you are writing make obvious sense to an outsider who might read them?

Theory notes are abstract and general statements about our practice. They attempt to reduce complex reality to a few general points. Without this reduction, our efforts to learn from one another can get bogged down in very particular details and problem-solving. As we try to generalize about our practice, we give up rich, particular detail in order to gain helpful knowledge to use in other situations.

An Example Theory Note

The following Insight Cards from a workshop formed a single category. The theme for the workshop was "bureaucratic barriers to good health promotion practice." The category was named "Developing Partnerships that Involve Funding."

Insight Cards

Need to recognize differing community capacities

Look at everyone’s evaluation needs and reconcile

Full inclusion involves all who are affected now and in the future

Need to resolve conflicting priorities

Participation must be broad, go beyond representative members of a group:

We don’t necessarily know what people need; they don’t necessarily know either

Funders promote dependency among providers and recipients

Funders need to understand that specific communities are at different stages of readiness for health promotion strategies

Continued...
An Example Theory Note (Continued) . . .

No theory note was written for this category by the story group, but such a theory note might look like this:

It’s important to take time to build community participation up front in any health promotion proposal development, especially if funding grants are part of the proposal. Funders can often promote dependency among providers and recipients involved in the project relationship by getting them to buy into projects of greater interest to the funders than to the communities. This dependency can be avoided by ensuring that potential recipients are always part of the process of deciding how and what issues and interventions should be funded.

Community participation in this process should seek to involve everyone who might be affected by the project. But participation must go beyond representative members of a particular group and seek as broad an input as feasible. When seeking this input, there is a delicate relationship between them and us. We don’t necessarily know what people need, but they don’t necessarily know either. As we dialogue around what both of us think is important to fund, we need to choose among numerous conflicting priorities. We also need to recognize that there are differing community capacities to participate in such a process. Funders in particular need to understand that specific communities are at different stages of readiness for health promotion strategies. We must pay attention to why, when and how community groups join us as partners in a project.

Finally, this up front participation must extend to evaluation. All of the different stakeholders should table their evaluation concerns. Further, as a group, they should reach consensus on what is important and how it is to be evaluated.

Composite Theory Notes

Once a theory note has been written for each of the categories, determine how they can be structured or linked together into a composite theory note about health promotion practice.

Writing a theory note by committee (story group) is very difficult. It’s better for one or two persons to take responsibility for one or two categories, depending on the number of categories and persons in the story group. Completed theory notes are read to the whole group and posted on a wall or flip chart paper. The group, or one or two members designated by it, decide the best order in which to organize the theory notes into a composite. Sometimes it helps to write a bridging sentence between the individual theory notes when writing the composite theory note.
Practitioners sometimes rebel against the word “theory.” Organizers should explain and demystify the word before beginning the second level synthesis. It also helps to share with the group at the beginning an example of a composite theory note generated by a similar Story-Dialogue meeting (one is given below). By knowing the end-product of the second level synthesis, they can see how the steps in the synthesis might be useful to them.

An Example Composite Theory Note

This composite theory note is adapted from one developed at the University of Toronto Health Promotion Summer School. It deals with how health promoters begin work with new community groups.

Health promoters must learn to recognize 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 not only more empowering; it is also often the only way health promoters can achieve credibility among many community members who are historically 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 to the 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, in part, “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.

When health promoters begin to organize and work with community members in groups, though, they should also be prepared to let the discussion “happen.”

Continued...
An Example Composite Theory Note (Continued) . . .

This doesn’t mean that discussions are allowed to ramble in an unfocused way. It does mean that forcing a focus too soon, or coming to the group with too fixed an agenda, can prevent the group from understanding what is most important to its own members.

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 recognize 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 – think of Gumby! 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 their overall way of working.

This theory note strikes a balance between the specific and the general. It contains statements that are fairly precise (a “capacity” approach to assessment, good process/task group skills, honest about an agency agenda) while remaining broad enough that these statements might apply to many different practice situations.

Using Theory Notes

Theory notes are helpful because they are statements about practice that derive from practice. They represent practice-based theory.

Theory notes are often the end product of a day (or longer) workshop that demanded a lot of preparation, concentration, emotional risk and plain hard work. Such a workshop should conclude with a plenary in which story groups read their composite theory notes. A circle is a powerful way to share theory notes.
Composite theory notes often point to more questions about practice. The example theory note above doesn’t address all of the issues that might confront health promoters seeking to organize 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? Such questions can become generative themes for subsequent Story-Dialogue meetings.

Composite theory notes should be collected, collated and distributed to all participants in a Story-Dialogue meeting.

USING CASE STORIES IN CASE STUDY EVALUATION

What Is a Case Study?

Case studies are some of the evidence we use to create a case study. A case study is a more complex form of investigation, often used to evaluate a project or to link together a broad range of insights from the viewpoints of practitioners, community members/participants, managers, or organizations. Case studies increase the validity and generalizability of case stories because they bring more types of evidence and more voices of experience to the Story-Dialogue Method. The methods for developing a case study are essentially the same as those for developing theory notes from a case story. The only difference is that the net of evidence and experience is much larger. (See Figures 2 and 3).

1. Description

As part of a case study, case story descriptive notes expand to include details on:

* the community setting (geographic, groups, individuals);
* the organizational setting (including our own professional roles within the organization);
* some of the history of the organization’s and the community’s past involvement with the problem or issue, and with each other;

The case study might also include:

* other peoples’ case stories (interviews);
* any other descriptive notes that would help a story-listener understand the “why” of what happened.
Figure 3: Case Study

<table>
<thead>
<tr>
<th>CASE STORY</th>
<th>INTERVIEW</th>
</tr>
</thead>
<tbody>
<tr>
<td>FIELD NOTES</td>
<td>PARTICIPANT OBSERVER</td>
</tr>
<tr>
<td>DOCUMENTS, REPORTS</td>
<td>SELF-INTERVIEW</td>
</tr>
<tr>
<td>NEW INFORMATION</td>
<td>DATA</td>
</tr>
</tbody>
</table>

CENTRE = KEY GENERALIZATIONS
Figure 4:

Increasing validity, credibility, generalizability of knowledge
2. **Explanation**

In a case study, the explanation stage includes many people and points of view. Even if case stories are the primary data used in a case study, program participants might bring a different understanding to the stories than would other practitioners. Inviting different points of view on the same case stories improves the stories’ validity. Validity is also improved by using multiple case stories within each case study, e.g. participants’ experiences, staff experiences, managers’ experiences and so on.

3. **Synthesis**

Case studies are built upon one detailed example. It is hard to generalize from one example to other situations. We confronted this when we discussed how to generalize about health promotion practice from a single case story. We found that when we compare our Insight Cards with those generated from other stories, we can make valid observations that are applicable to other situations. To do this, we link Cards together into a meaningful and credible category. We write up composite theory notes that bind our conclusions together into a comprehensible statement.

In case study evaluation or research, generalizability describes similar efforts made by people involved in the project to argue why some of the lessons they have learned (about practice, about communities, about health promotion strategies) might be important to practitioners in other situations. We can improve the accuracy and usefulness of our generalizations in case study evaluation by:

* Finding similar case studies, either in the literature or among our peers, and comparing the lessons. The structured dialogue can be used in this process; that is, the case studies are treated as case stories.

* Ensuring that there are “thick” descriptive notes about the project. The notes should have enough detail that other persons in other practice situations can draw their own useful conclusions about whether the practice lessons drawn by case study authors also apply to them.

**Case Stories Within Case Studies**

Participants, staff, supervisors and other key project stakeholders 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; it is most useful when each story group has story-tellers with different points of view. Insight Cards, categories and theory notes are generated to the extent they prove useful to the project. New action strategies are planned following the plenary in which theory notes are shared. 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 action plans.

Case Stories Across Case Studies

The Story-Dialogue Method lends itself particularly to projects such as Healthy Communities, Heart Health Coalitions or other initiatives 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 work.

Case Stories in Conventional (Quantitative) Evaluations

"Most development agencies produce written documents as part of the evaluation process, but the inclusion of oral accounts (case stories) can introduce a wider dimension and correct an almost inevitable bias towards quantitative goals and objectives," Slim and Thompson, 1995

The Story-Dialogue Method can be used to accompany any form of program evaluation, regardless of its research approach.

Case stories, insights generated through a structured dialogue, and composite theory notes can all form statements of meaning within an evaluation report.

Case Stories of Evaluation Reports

The Story-Dialogue Method can also be used to examine and validate draft evaluation reports. Key stakeholders in the project (staff, community participants, funders) review the report for any generative themes it contains. Case stories are prepared on these themes from the differing viewpoints of the key stakeholders. The stories are shared in rounds, ensuring that each story group has at least one story-teller from each stakeholder group. The results of a Story-Dialogue meeting on the draft report become part of the final report and its conclusions.
Structuring Dialogue Around Case Studies

The structured dialogue technique is also useful when hearing case study presentations at conferences, meetings and workshops. The structure of the open questions invites us to create knowledge from what we hear, rather than just absorb information that presenters provide. But to make use of the open questions, we also have to reflect continually on how the case study speaks to our own practice issues. This means letting go of the drama of the particular case, and hearing what lessons it might contain for us.

Reflecting on a Case Study

One case study at the University of Toronto Health Promotion Summer School concerned a health promoter's organizing efforts in the Somali community around the issue of female genital mutilation (FGM). The presenter made several points about the case that were pertinent and generalizable to health promoters:

**Case Study Comments**

- White feminist women with good intent often preached to women of colour on what they should do to end this form of oppression
- Project began when concern was expressed by Somali women themselves
- Some East African groups reject FGM completely; some for their daughters only; some are ambivalent; some are in favour
- Media a mixed blessing; raised FGM issue but stereotyped Somali community around that one issue

**Practice Reflections**

- Well-meaning professionals often impose their sense of what is important and right on less powerful communities
- Always start work with a base in the community
- Identify key stakeholders to an issue; determine their interests and positions; organize differently for partners (those who agree), potential partners (those who are ambivalent) and resisters (those opposed)
- Need to use media more carefully to raise groups' issues, but also to identify groups' capacities and complexities

Many of the case study listeners became caught up in the details of the FGM issue rather than with what the details revealed for health promotion practice. Only by reflecting carefully on how a case study relates to one's own practice can a structured dialogue help practitioners learn more useful general knowledge from the particulars of one case study.
CHAPTER 8

SHARING YOUR EXPERIENCE IN USING THE STORY-Dialogue METHOD

We differ in our motivations for using stories in health promotion practice. Our organizational settings and type of practice also create differences in how we apply the Story-Dialogue Method to improve our work. Many of us believe that this Method can offer practitioners a useful way to participate in knowledge development in health promotion. It helps to bridge the gulf that sometimes exists between research and practice.

You can help us refine the Method and learn more about how it aids practice. Using the following outline, make a record of how you used the Method, things that worked well, things you would do differently next time.

Please share your account with us so that we can learn more about uses of the Method and improvements that should be made. Please include the name, address, phone number and fax number of someone who could tell us more about your experience if we need to contact you. The information you provide will be held in strict confidence. Send your account to: Handbook Review, Prairie Region Health Promotion Research Centre, University of Saskatchewan, Health Sciences Building, 107 Wiggins Road, Saskatoon, SK S7N 5E5 Phone (306) 966-7932 FAX (306) 966-7920.

1. What was the purpose of using the Story-Dialogue Method? Was it used for solving a problem involving a single case; developing knowledge from more than one case (e.g. in professional development or staff training); evaluation of a program or activity; planning a program or activity; or some other purpose? Who organized the event where the Method was used, and why?

2. Describe the people taking part (e.g. practitioners, managers, community volunteers,...). How many people were involved in the Story-Dialogue Method?
3. Describe how you used the Method, including: instructions to participants; preparation of stories; story group process including roles of participants; insight cards; development of categories; development of theory notes; plenary discussion; use of a facilitator.

4. Did you evaluate the event? What did participants and organizers say about it?

5. What part(s) of the Method worked particularly well? When did participants show the most enthusiasm and energy?

6. What part(s) posed the biggest challenge to the organizers and/or participants?

7. What would you do differently the next time?

8. What recommendations do you have for revising the Method or the instructions about the Method?

THANKS FOR YOUR HELP!
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South Australian Community Health Research Unit. Planning Healthy Communities. Bedford Park, South Australia: South Australia Community Health Research Unit, 1991.


University of Toronto. University of Toronto Centre for Health Promotion, Health Promotion Summer School. "Approaches for Promoting the Health of Individuals and Communities." Toronto, ON, June 5 - 9, 1995 (unpublished notes).


The Centre for Development and Innovation in Health in Australia has developed a program to help community health workers develop case studies using their own practice stories. Part of this program are two half-day workshops with small groups of practitioners. The first workshop discusses how to write a good story. The second workshop reviews the stories to help develop them further into case studies. The Centre has published materials on their workshops, and two books of case studies (Case Studies of Community Development in Health 1993, and Innovation and Excellence in Community Health 1994). For more information write:

Centre for Development and Innovation in Health, PO Box 57, Northcote, Victoria 3070, Australia.
Appendix 1

Some Generative Themes in Health Promotion Practice

These themes below share much in common. They all express tensions in our practice. They describe some of the difficulties and challenges we experience in implementing health promotion strategies. They also reflect the different emphasis or ways of framing practice concerns across the country.

1. Explaining Health Promotion's Importance

Health promotion is still not well understood by senior bureaucrats or political decision-makers. Because it involves ideas like community development and empowerment, it is often hard to explain in bureaucratic terms why certain health promotion practices or programs are important. Many health promoters are low on the bureaucratic hierarchy, and do not feel they have access to decision-makers to argue for health promotion’s importance.

2. Community Development

Community development poses numerous challenges in health promotion, such as defining “community,” being explicit about values (the practitioner’s and the community's), being flexible and responsive to changing community needs, and evaluating the impact of development work. Many practitioners feel that community development is essential in health promotion but that their formal training has not equipped them to be effective. Others struggle to reconcile the policies of their own organizations and the community's needs.

3. Bureaucratic Barriers

Health promotion is socio-environmental in orientation, incorporating disease prevention but expanding to include the social determinants of health. Many health organizations still operate with planning models, evaluation methodologies and accountability or reporting systems based on a disease prevention approach to health promotion. At the same time, these organizations recognize the importance of a broader, socio-environmental approach to health promotion, where issues of poverty, unemployment, environmental sustainability, discrimination and powerlessness (to name only a few) become important health concerns.
APPENDIX 1 (Continued) . . .

Health promotion practice uses approaches, such as community development, that require professional flexibility, power transfers to community groups and different accountability methodologies. This creates a tension between an “old” system of accountability and a “new” paradigm of practice.

4. Evaluation

Epidemiological, disease-based methods of evaluation rely heavily on quantitative methods and aggregated data which are not always relevant to health promotion practice. Actions aimed at changing the environment or conditions of people’s lives call for different approaches to evaluation. Yet practitioners are sometimes required to account for their work in strictly quantitative terms, when this seems quite inappropriate.

5. Needs Assessment

Increasingly, health promoters are being asked to justify future programs by doing a health promotion needs assessment. But what is a “health promotion need,” who assesses it, and how? How can provincial, regional and local efforts to assess needs be co-ordinated? Can there be a standard approach and still allow for flexibility? How are needs reflected in strategic planning? What structures and processes ensure meaningful citizen participation in health policy development and planning?

6. Health Reform

The main elements of health reform are decentralization, more public participation, fewer resources for all health programs (medical, behavioural, socio-environmental) and more emphasis on outcome-driven forms of evaluation to justify ongoing expenditures. Sometimes it is asserted that health promotion is integral to achieving the goals of health reform. And yet it is often left outside the jurisdiction of the new decentralized health authorities. It is not always clear how or where health promotion “fits” in a reformed health system. What structural supports are required for it to “fit”?
APPENDIX 1 (Continued) ...  

7. *Determinants of Health*

Recent publications and pronouncements by provincial health councils and others have drawn attention to broader determinants of health. Health promotion practitioners try to focus on these determinants, or "risk conditions," instead of only addressing isolated risk factors such as personal behaviours. But how can the public and policy makers be educated about the significance of this shift? How can our knowledge of the determinants of health be converted into action?

8. *Power*

Power relations affect all actions in health promotion and community development. Power inequalities are health risks in their own right. Many practitioners who wish to work in an empowering way are immediately confronted with their own contradictory social location:

* They work in governments that function as agents of social control and management and they claim to work in ways that lead to actions to change inequalities in our social relations of power.

* They work in institutionalized health and welfare programs that have become disabling for individuals, producing unhealthy dependency and "powering-over" program clients. This leads to calls to transfer control and responsibility for these programs to the "community." And these programs arose, in part, because of the very failure of local communities to provide for all its members.

* Hierarchies and inequalities exist within the institutions in which they work. And their empowerment practices are dedicated to flattening hierarchies and reducing inequalities between professionals and clients, institutions and communities.

* Professionalism is often self-interested, and blind to its own class (in terms of gender, ethnoracial identity, educational or income privileges and status); and professo, a Latin word that is the root of "professional," and which means a vow to share with one's community all that one earns.
APPENDIX 1 (Continued) . . .

9. Participation

Participation has become a buzzword in all government practices. This is both a blessing and a bane for community groups. Participation in groups can be health-promoting in its own right, strengthening our bonds with one another. Participation in policy/political decision-making can increase our community's capacity to act on important health determinants. But participation can be token, largely because the terms of participation/consultation are often set by institutions. Despite recognition that supports for citizen participation are essential they are often meagre or lacking. There's also a general participation exhaustion with everyone running from one consultation meeting to another in the hopes of not missing something that just might be important, but often is not.

10. Partners

Everyone talks about the need to develop new partnerships or intersectoral collaboration. The health sector has even been charged with becoming the leaders in this process. Our work should lead us beyond ourselves, to partnerships with like-minded (or potentially like-minded) groups, organizations, sectors. But territoriality, competition over resources, different language and concepts, different accounting structures and priorities all seem to get in the way. The only examples of authentic partnerships seem to exist at very small, almost neighbourhood levels, not at the policy levels everyone thinks is important. Within communities, and certainly between communities and government, conflicts and power struggles are often present, even if they are not openly acknowledged.
APPENDIX 2

A GLOSSARY OF TERMS USED IN THIS MANUAL

Case Story:  A personal (first person) account of an event. A case story describes an event (a project, a program) from health promotion practice.

Case Study:  An account of an event (a project, a program) drawing on many sources of data. These sources can include case stories from several practitioners and participants, project reports, minutes of meetings, process evaluation reports and so on.

Facilitator:  A member of a story group experienced with, or briefed on, the Method. A facilitator can also be a story-listener.

Generalization:  In the context of health promotion case stories and case studies, determining what lessons about practice learned in one project or program might apply to other projects or programs.

Generative Theme:  A problem or issue that generates animated discussion and energy among people. Case stories are prepared around generative themes.

Insight Cards:  Brief statements of key lessons learned from each case story.

Practice:  This term is used frequently in the Manual. It refers to what health promoters actually do, and to what it is they think they should be doing. While the Manual is written primarily for health promotion practitioners, practice can also mean the work or involvement of community members in health promotion projects. There are two important dimensions to the word that apply to everyone:
APPENDIX 2 (Continued) . . .

1. It involves action;
2. It is something from which we continually learn.

Reflect: To think about one’s experience and express thoughts and opinions about it.

Rigour: In research, the efforts made to ensure that findings reflect as accurately as possible what happened. Different research approaches have different methods to achieve this rigour. What they share in common is the researchers’ hard work to generate useful and credible knowledge.

Second Level Synthesis: Combining the lessons (Insights Cards) from several case stories, into a more generalized lesson for practice.

Story-Dialogue Method: The rigorous use of stories for knowledge development, evaluation, research, planning and team building. The Method involves preparing and using case stories in a structured dialogue, usually leading a second-level synthesis of more generalized lessons about practice.

Story Group: Case stories are usually shared in small groups (3 to 12 people). The structured dialogue always occurs in small groups. These small groups are referred to in this Manual as story groups.

Story-Listener: The person listening to a story in a story group.

Story-Recorder: The person recording key insights generated during a structured dialogue. Story-recorders can also be story-listeners. Notes from story-recorders are used to create Insight Cards.

Story-Teller: The person sharing their story in a story group.
APPENDIX 2 (Continued) . . .

Synthesis: The assembling of separate parts into a whole; a complex whole composed of originally separate parts; the opposite of analysis (Funk & Wagnalls Canadian College Dictionary). Drawing from the details of a case story, the general lessons we can learn for practice.

Triggers: A concrete expression of a generative theme. Triggers contain information about the social context, allow participants to project their emotional and social responses in a safe environment, focus on one concern, are open-ended (posing problems rather than solving them) and promote critical thinking and dialogue around the issue. Case stories in the Story-Dialogue Method are triggers.

Validity: The extent to which our explanation for case story events accurately matches our description, and represents the "best" account of what happened.

Theory Notes: A theory note describes the Insight Cards organized within a category, and combines (synthesizes) these Cards into an understandable statement. After a theory note has been written for each category, the theory notes are linked together into a composite theory note about health promotion practice.