EXPERIENCES OF PHYSICAL THERAPISTS NOT-KNOWING DURING INTERNATIONAL SERVICE-LEARNING WORK

A DISSERTATION
SUBMITTED TO THE FACULTY OF THE GRADUATE SCHOOL
OF THE UNIVERSITY OF MINNESOTA
BY

Susan Geraldine Klappa

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY

Dr. Jane Plihal, Adviser

April, 2010

© Susan Geraldine Klappa, 2010

Acknowledgements

I'd like to thank:

My adviser, Dr. Jane Plihal, and my doctoral committee members, Dr. James Bequette, Dr. Linda Brady, and Dr. Jerry Stein.

My husband, Stephen Klappa.

My children, Kirsten, Tony, Scott, and Paul.

My friends and colleagues, particularly Maureen Schriner and Hui Hui Wang.

My editor, Jennifer Manion.

The American Physical Therapy Association Health Policy and Administration Section Cross Cultural and International Special Interest Group

All of the people who responded to my recruitment notice.

Dedication

This dissertation is dedicated to the 20 participants who were willing to speak to me about their experiences of being stuck or not-knowing what to do while participating in an international service-learning work. It was an honor to meet them and listen to their stories. I have tried to be diligent in my attempt to represent their words as they were spoken to me. I have tried to share their very personal stories in a way that honors their experiences in a compelling and truthful manner.

Abstract

Not-knowing implies that one does not have knowledge of something, to not be sure of something, or to not be able to recognize or identify something. When one finds oneself in a moment of not-knowing, he or she is in a state of being unaware or not informed. As members of a profession, physical therapists act as clinicians, educators, administrators, consultants, and researchers. Opportunities are now available for physical therapists to move onto the global scene as they become involved in international service-learning (ISL) work. Professional core values and a code of ethics set the stakes on knowing quite high. The familiar experience of performing one's professional duties is altered by the context of the international setting. Not-knowing, consequently, holds serious implications professionally and personally for those who are supposed to know while engaging in ISL physical therapy work.

This research project examined the phenomenon of not-knowing for physical therapists engaging in ISL work. Descriptive phenomenological methods were used to analyze interviews of 20 physical therapists on the topic of not-knowing during ISL work. Data were collected from two interviews with each participant in order to create the general structure of the experience of not-knowing. The interview transcripts were analyzed using the descriptive approach described by Giorgi (1975, 1997) and Dahlberg, Drew, and Nyström (2002). This process involved a whole—parts—whole type of holistic examination of the interview texts until the constituents of the experience were revealed. Descriptive phenomenology was used to describe the experience of not knowing what to do for physical therapists engaged in international service learning work.

The structure of not-knowing was described as periods of surprise, shock, anger, guilt, and self-doubt, before being transformed by the experience and being able to move forward into action. The essence of not knowing for physical therapists engaged in international service learning work was signified by four constituents which included (a) Facing limitations — Surprise or shock: Oh, my God!; (b) Strategizing and improvising: On the fly by the seat of my

pants; (c) Professional identity and self doubt: I feel like an imposter; and (d) Illumination and clarity: When the light bulb turned on!

The constituents revealed in this study have implications for physical therapists and health care workers who engage in international service learning work and for the programs which sponsor this work. By better understanding the physical therapists' experience we can better anticipate the kinds of support needed for those who engage in international service-learning work. Seeing moments of not-knowing as opportunities to learn may provide us with a cornerstone for building better relationships with people involved in health care across cultures and nations. The capacity to teach and practice life more sensitively is brought to light after an experience of not-knowing in an ISL setting for the physical therapist participants in this study.

Key Words: Not-Knowing, Descriptive Phenomenology, Physical Therapist, International Service- Learning

Table of Contents

TITLE PAGE

ADVISER'S SIGNATURE PAGE

NOTICE OF COPYRIGHT

ACKNOWLEDGMENTS……………………………….…………………………...…i

DEDICATION…………………………………………..………………………ii

ABSTRACT……………………………………………………..…………..…iii

TABLE OF CONTENTS…………………………………………………………….v

LIST OF TABLES…………………………………………………………….…..viii

SECTION 1: INVESTIGATING NOT-KNOWING………………….……………….…1

CHAPTER

I. A FASCINATION WITH NOT-KNOWING……...…...…………..……...…..…3

Situating the Experience: Who Are Physical Therapists?....................................6

Physical Therapists, Not-knowing, and the International Setting……………..…7

Gaps in the Literature…………………………………………………………...13

Summary………………………………………………………………….…..15

II. THE PHENOMENON: NOT-KNOWING………….……………………….…....17

Knowing and Not-knowing……………………………………….……….18

Understanding Professional Identity……………………………….………...21

A Calling, a Vocation?……….……………………………………….……...23

Clinical Decision Making and Actions: Improvisation………………...………25

Summary……………………………………………………….……….…....30

III. STUDYING THE PHENOMENON……..…….…………………………….….…....32

Phenomenology Explained…………………………………….….….….32

Phenomenological Terms…………………………….....……...38

Lifeworld…………………………………………….….…38

Spatiality, corporality, temporality, and relationality……39

Essence……………………………………………...…...39

Reduction and bracketing………………………...……40

Imaginative variation……………………………….……...41

Merleau-Ponty: Holism, Embodiment, and Culture………..……42

Methods, Procedures, and the Research Process: Finding Answers…..…45

Bracketing Process………………………………...……......46

Recruitment……………………………………………..…47

Conducting Interviews………………………….…….….……49

Analysis…………...………………………………………..53

Individual (vertical) analysis………………..…...……54

Thematic (horizontal) analysis……………………..........56

Resonance Rounds…………………………………………….60

Methodological Rigor in Qualitative Research…………………..64

Summary………………………………………………….....69

SECTION II: RESULTS……………….……….…………………………….…………70

CHAPTER

IV. THE GENERAL STRUCTURE OR ESSENCE OF NOT-KNOWING……….....71

V. DISCUSSION……………………………………..…………………………..….80

Constituent #1: Facing Limitations — Surprise or Shock:

Oh, my God! ………..………80

Constituent #2: Strategizing and Improvising: On the Fly by the

Seat of My Pants...112

Constituent #3: Professional Identity and Self Doubt: I Feel

Like an Imposter…………………………………………….………121

Constituent #4: Illumination Provides Clarity: When the

Light Bulb Turned On!………………..………………….....……134

SECTION III: PERSONAL AND PROFESSIONAL IMPLICATIONS……….……..145

CHAPTER

VI. POSTSTUDY REFLECTIONS…..…………………………..……........................147

Why Not-knowing in ISL Work?…………………...………………...….……....147

Moods: Understanding Not-knowing and Ourselves…………………….….……149

Relationships: Outsideness and Insideness…………………………....………..152

Strengths of the Study and Wondering about New Things……….……154

Implications for Physical Therapists……………………………..….…………158

Concluding Thoughts and Reflections……………………………………………161

VII. LIVING WITH NOT-KNOWING………………………………………….……….…162

Lessons Learned…………………………………………………………...….165

Concluding Reflections……………………………………….…………….…..166

REFERENCES……………………………………………………………....……..169

APPENDICES

APPENDIX A: Participant Recruitment Flyer…………………...…..…179

APPENDIX B: Participant Consent Form……………………...…..…..180

APPENDIX C: Interview Guide……………………….….....……..…182

APPENDIX D: Overview of my Research Approach……….……..…183

List of Table

TABLE PAGE

3.1 Initial Ideas on Constituents…………………...……………..………..58

3.2 Final Constituents for the General Structure of Not-knowing………..60

Experiences of Physical Therapists' Not-Knowing During International Service-Learning Work

Section I: Investigating Not-Knowing

No student knows his subject: the most he knows is where and how to find out the things he does not know.

Woodrow T. Wilson, 28th president of the United States

My dissertation research process involved developing my research question and seeking a methodology to help me find the answer. My research question arose out of experiences I encountered in my everyday life as a physical therapist engaged in international service-learning (ISL) work in the Dominican Republic. In the Dominican Republic, I had several moments of not knowing what to do or how to proceed when working with patients and clients. Sometimes my moments of not-knowing were related to the severity of the patient case I faced. Other times, my not-knowing was due to limited available resources or the fact that, in response to a particular patient case, I was not in my comfort zone as a clinician.

I have also had moments of not-knowing in Mexico, Venezuela, Honduras, and Haiti, each time while engaged in ISL work. I've also experienced moments of not-knowing in my physical therapy practice at home in the United States. However, when in the United States, I did not find such instances as difficult or paralyzing as I had when abroad; in the United States, I could always seek resources and others' opinions more easily than I could when working farther afield.

In seeking answers about the phenomenon of not-knowing, I believe it is important to return to the thing itself and ask people who have had experiences of not-

knowing in the ISL work setting about their experiences. In this first section of my dissertation, I describe my research journey, beginning with one of my own moments of not-knowing. In Chapter One, I describe my fascination with not-knowing and consider the physical therapist as a professional; I also identify gaps in the literature. In Chapter Two, I discuss the phenomenon of not-knowing and its effects on professional identity, issues of self-doubt, and clinical decision-making through improvisation. In Chapter Three, I discuss phenomenology, my research process, and methodological rigor in phenomenological research.

Chapter One

A Fascination With Not-Knowing

I stand stock still for a moment, paralyzed by my thoughts and what I have just seen, although I quickly return to the reality that my own six-year-old son is in front of me, a very disturbed, concerned look on his face. He implores me to do something. An urgency that I have never heard before tinges his voice. “You’ve got to do something, Mom. You’ve got to fix her,” he insists. My 12-year-old son also chimes in. “Mom, you’re a good PT. Thank goodness you’re here. You’ve got to do something to help Lisbeth walk better. She can’t keep going on like this. She could really get hurt. I’ve never seen anything like this,” he states emphatically.

In truth, none of us have ever seen anything quite as severe as the gait pattern we have just witnessed by Lisbeth, the little four-year-old Dominican girl we are examining at the retreat center in the Dominican Republic. Interestingly, the “us” includes me, three student physical therapists, and the director of the service-learning program, as well as a physical therapist from the United States. Standing by are Lisbeth’s family and friends. My two boys and my husband are in the room working on another project; they witness Lisbeth’s gait pattern. I am the clinical instructor who is the physical therapist team leader responsible for examining Lisbeth during the community physical therapy clinic at the retreat center this afternoon.

I complete the patient history, subjective and objective exams, and am now watching Lisbeth walk without her shoes. Lisbeth is the niece of our driver, Rafael. He has heard about our afternoon physical therapy clinic and has previously seen us in action

with other patients. Rafael contacted his brother to bring his niece by for a consultation. Rafael has such hope for his niece. Lisbeth has spina bifida, yet it is at a low enough level that she had a fair amount of functional strength in her lower extremities. She specifically lacks strength, proprioception, and sensation from her ankles down. She has been carried everywhere by her parents, but, because she is growing rapidly, this is becoming rather difficult. The family does not want Lisbeth to wear braces because of the stigma active in their community that attaches braces to having a disability. In the Dominican Republic, having a disability may lead to a person's marginalization; it can be a possible life sentence, condemning a person to begging in the streets or being hidden away from society. Lisbeth is a charming, smart, and precocious young girl who can count to 20 in Spanish, English, and French. She wants to be a physiatrist (a physician who specializes in physical medicine and rehabilitation) when she grows up because she wants to help other children walk better.

I am not sure if it is the fact that I have just witnessed a child walking on feet that look like they have been put on backwards and upside down, or if it is the fact that my own sons are so concerned about a little girl they have just befriended that afternoon. Of course, there is the added pressure of other professionals looking on. Family and friends also look to me for an answer about how to make Lisbeth a normal girl. Lisbeth's gait pattern is something I have heard about in physical therapy school but have never ever witnessed, even in my student rotation days at Children's Hospital. Time seems to slow down as I frantically try to figure out what we can do for Lisbeth, despite our limited supplies and resources.

People seem to stare at me with desperate hope for an answer that will change a young girl's life for the better. My heart beats quickly, and I can almost hear the synapses firing in my brain like muffled firecrackers as I try to make sense of everything. I feel hopeless, afraid that I will disappoint everyone if I cannot find an answer for Lisbeth. Feeling the weight of this young girl's life in my hands is a terribly huge burden. I don't know what to do, and I do not know if I should let others know I am puzzled. "Think! Think!" I tell myself as I try to maintain a professional façade. Inside, I panic and my brain moves at what seems like a thousand miles an hour. Suddenly, when I think all is hopeless, an idea comes to me like a light bulb turning on in my mind. I can then see clearly what our plan will be for Lisbeth.

That moment of not knowing what to do, or feeling "stuck," has intrigued me as I have reflected on it many times since that day. It was not the first time, nor would it be the last time, that I experienced such a situation during international service-learning (ISL) work. This moment and others like it are profound because of the responsibility I feel for my patients and, perhaps selfishly, because of the responsibility I feel for my credibility as a physical therapist professional. In short, I do not want to fail for the good of others and myself.

In my experience, moments of not knowing what to do or being stuck when in another country during a service-learning experience seem so much more profound than those I have experienced in a clinical or classroom setting in the United States. I have often wondered why this is so, and more importantly, if others have had similar experiences while on international assignment. Through cautious, casual conversations with other physical therapists involved in international service-learning work, I have

learned that being stuck or not knowing what to do is a relatively common experience and yet the gravity of the situation in which the phenomenon of not-knowing occurs may result in a paralyzing moment of questioning. One may be filled with self-doubt when unable to see how to proceed with treatment. Further, one may question more than one's own lack of knowledge in the moment; one may question one's professional identity. Finally, other questions arose for me as I considered the phenomenon of not-knowing: Are others willing to talk about the experience? What is the experience of being stuck or not knowing what to do for physical therapists involved in ISL work? What exactly is the experience of feeling stuck during ISL work and what is the essence of not-knowing? Why should this phenomenon matter to our profession of physical therapy?

Situating the Experience: Who Are Physical Therapists?

Physical therapists are one of many allied health professionals who work to improve the physical function and health of individuals and communities. They diagnose and treat individuals of all ages, from newborns to senior citizens, who have medical problems or other health-related conditions that limit their abilities to move and perform functional activities of daily life (APTA Fact Sheet, 2009). Physical therapists provide care for people in a variety of settings, including hospitals, private practices, outpatient clinics, home health agencies, schools, sports and fitness facilities, work settings, and nursing homes (APTA Fact Sheet, 2009; APTA Guide, 2003a). Traditional, everyday experiences for physical therapists involve examining individuals and developing care plans using treatment techniques in order to promote the client's ability to move, experience less pain, regain function, and avoid disability. Physical therapists are also taking on roles beyond patients or clinical care. They may take on roles as

administrators, consultants, teachers, and researchers. Physical therapists are also becoming involved in the global health setting through ISL work.

Historically, physical therapists have been educated at the certificate, bachelor's, or master's degree levels. The minimum educational requirement for physical therapists currently is a post-baccalaureate degree from an accredited education program (APTA Background Sheet, 2009). Most programs educating physical therapists have now progressed to the doctor of physical therapy (DPT) degree level due to advancements in the profession, increased professional autonomy, and the use of evidence-based practice within this doctoring profession (Hiller & Swisher, 2009; Kirsch, 2009a; Kirsch, 2009b;). Currently, 199 colleges and universities nationwide offer accredited professional physical therapist education programs, with 92% offering the DPT degree and the remaining programs with plans to convert to the DPT level (APTA Background Sheet, 2009). Physical therapists must also be licensed in the state or states in which they practice (APTA, 2003a). Finally, core professional documents (Vision 2020) talk about being a member of a doctoring profession, thus setting the stakes on accountability and knowing quite high.

Physical Therapists, Not-Knowing, and the International Setting

My interests in physical therapy, international service-learning work, and feminist pedagogy, as well as my relationships with international health care organizations, have led me to focus on the research question: What is the experience of physical therapists being stuck or not knowing what to do during ISL work? As a relatively new opportunity, ISL physical therapy work has been gaining in popularity (APTA, 2008b; Pechak & Thompson, 2009). Service-learning is defined as "a structured learning

experience that combines community service with explicit learning objectives, preparation, and reflection" (Seifer, 1998, p. 274). Furthermore, service-learning describes more than an educational program. It is a philosophy of education that emphasizes "active, engaged learning with the goal of social responsibility" (Kendal, 1990, p. 22).

International service learning (ISL) for student physical therapists is operationally defined by Pechak and Thompson (2009) as "a service-learning opportunity that occurs outside of the country where the education program is located" (p. 1194). In this study, ISL work will be defined as service-learning work that occurs outside a physical therapist's country of origin or site of physical therapy education. No matter the setting, service learning has the potential to be highly successful or a failure, depending on the preparation one receives. When physical therapists cross the borders of their homelands to practice therapy internationally, they often experience a sense of wonder and adventure, and they bring with them their educations, clinical experiences, skills, and competence. Yet, a surprise or unexpected moment can alter a physical therapist's ability to retain his or her normal decision-making clarity. Fontes (2008) states the following:

> We need to be especially cautious when working with a person from a culture that is different from our own, where we are less apt to understand the full implications of what we say and do. The risk of accidentally stumbling into an ethical minefield is greater in cross-cultural encounters. (p. 7)

There are thus good reasons why a physical therapist's decision-making capacity may become suspended; he or she may be unclear about a culture's ethical framework, or not grasp culturally endorsed practices.

Participation in physical therapy ISL work is often framed in the name of beneficence, of doing good and helping others, with little focus on the actual experiences of those doing the work. Differences in languages, culture, and location all add to the challenges a physical therapist may face when working in an international setting (Illich, 1968; Peace Corps, n. d.; Van Engen, 2000; Vanderhoff, 2005). When navigating through a maze of new rules in unfamiliar countries, physical therapists may experience contradictory, unsettling, or confused feelings, as it they were walking tight ropes. In addition to being unfamiliar with local customs and practices, they may not want to offend others or be seen as ugly Americans who impose their views on others.

International programs providing physical therapy to other countries have held privileged opportunities to be the official spokespersons for those offering assistance by facilitating interventions in other countries (Gold, 2009; Pechak, 2009; Van Engen, 2000;Vanderhoff, 2005). Van Engen (2000) and Illich (1968) suggest that government aid programs, international health programs, and nongovernmental organizations (NGOs) have been freely provided a platform to be the official spokespersons on this topic, but physical therapists are the ones engaged in this work, experiencing the day-to-day struggles, and typically they have not shared their experiences in the literature.

This study seeks to extend that platform to physical therapists to share with others their experiences of not-knowing, specifically when engaged in international work. As readers of the stories, we enter into and share in the experiences of these therapists. In doing so, we may identify with their stories and learn from the challenges or struggles faced by those having the experience of not-knowing in the international setting. Searching for the meaning behind not-knowing situates this study in phenomenological

research. Thomas and Pollio (2002) state that knowing and understanding another's experience involves "striving to understand an event as it has meaning in the life of the other" (p. 254). In a phenomenological study, a moment of shared understanding or deeper meaning occurs between the researcher and participant. In such studies, researchers look *with* participants at the phenomenon rather than *at* the participants in the given phenomenon (Thomas & Pollio).

Thomas and Pollio (2002) further suggest that phenomenology provides the researcher with a first-person perspective that permits the researcher and others to be able to enter into the lifeworld of the person living the experience. Researcher and participant thus make a powerful personal connection, one that encourages shared meaning and understanding. This type of qualitative research connects us as researchers to our participants in such a way that we enter into a relationship of reciprocity, wherein we move away from doing things to our participants toward connecting with our participants as they live through or recount their experiences. Merleau-Ponty (1945/1962) notes the benefit of transcending our isolation and connecting with others through language:

> The phonetic 'gesture' brings about, for both the speaking subject and for his hearers, a certain structural co-ordination of experience, a certain modulation of existence, exactly as a pattern of my bodily behavior endows the objects around me with a certain significance both for me and for others. (p. 225)

During such an encounter, according to Merleau-Ponty, "a fresh law reveals itself to the subject or to the external witness" (Merleau-Ponty, 1945/1962, p. 225).

The physical therapists interviewed in this study found themselves in unfamiliar settings during ISL work. Despite being holders of specialized knowledge, the

knowledge did not always appear applicable to the setting in which they were situated. Yet, these physical therapists were called to act. At the time of their not knowing what to do, they felt alone. Subsequently, they faced the challenge of feeling isolated while attempting to make sense of their situations and their responses. As Merleau-Ponty notes, connecting with another person through story telling is one way to transcend such isolation. Macann (1993) further explains what can come from sharing stories of not knowing what to do:

> To experience oneself as being cut off from the other is to hold open the possibility of a transcending of this isolation, an integration of my being with that of the other which, precisely because it is that of an other, permits me to transcend myself in my very being-with-the-other, to experience myself as something more than I am given to be by myself. (p. 192)

By sharing their stories with others, the physical therapists in this study brought new meaning to their experiences of not-knowing and allowed others to gain new perspectives on this phenomenon. Yet, when people share stories with other people, a reciprocal exchange occurs. The listeners gain new insight into a shared world and its meanings through an authentic connection with another. Merleau-Ponty (1945/1962) describes this connection when he writes, “We are collaborators for each other in consummate reciprocity. Our perspectives merge into each other, and we coexist through a common world” (p. 413).

Martin Buber (1958/1986) calls this authentic connection between humans an I-Thou encounter, writing, “As experience, the world belongs to the primary word *I-It.*

The primary word *I-Thou* establishes the world of relation" (p. 21). Thomas and Pollio (2002) elaborate on Buber's concept of the I-Thou relationship:

> We experience the world in two different modes: I-It and I-Thou. Every person takes one of two relational stands in regard to the social and natural world, and it is only in this stand that the specific nature of the I exists. Because the pattern of this relationship defines what sort of a person I am at the moment, the I of an I-Thou relationship is different from the I of an I-It relationship. In the case of I-It, the I relates to everything in the world as an object to be sensed, used, or categorized. (p. 104)

What might it be like to be a physical therapist facing the unfamiliar or unknown in an international setting? Learning from the stories of those who have found themselves in this situation can provide the answer, and there are important implications for learning about the lived experiences of physical therapists and the challenges they face when working internationally. Doing so may help us better understand the tensions inherent in and the deeper meaning behind professional identity and not-knowing.

The purpose of this study is to investigate the everyday experiences of physical therapists experiencing not-knowing during ISL work. I will describe the experience of not-knowing from the perspective of those who have experienced the phenomenon. At first glance, one might be surprised learning that such professionals experienced moments of not-knowing. After all, these physical therapists had survived the competitive process of gaining admission to physical therapy education programs, graduated, and passed their national board exam. They had successful practices in clinics, hospitals, schools, industry, and other venues here in the United States. Their professional identities and

roles were well established; these physical therapists could even have been considered expert practioners or leaders in their given area of physical therapy practice. Nevertheless, they found themselves unsure how to proceed. What was it, one might ask, about them or the situation that contributed to this response?

When participating in an ISL experience, oftentimes the subtle cues for professional engagement are not explicit, and listening to the stories of physical therapists who found themselves unable, even just momentarily, to pick up on these cues can reveal the intricate structure of perception and response. "The purpose of phenomenological research is to describe the structure of an experience, not to describe the characteristics of a group who have had the experience" states Polkinghorne (1989, p. 48). Research in this manner provides "a deeper understanding of the nature or meaning of our everyday experiences" (van Manen, 1997, p. 9). In this study, I describe the instances of not-knowing or being stuck that these professional physical therapists experienced so that other physical therapist practitioners, educators, and organizations that provide care in an international setting can glean new insights.

Gaps in the Literature

The general absence of writing on the experience of not-knowing in the professional physical therapy, nursing, and the medical literature suggests that researchers have not studied the phenomenon. One exception is the example in the field of social work by Ben Anderson-Nathe (2005). He conducted a phenomenological study on youth workers who experienced moments of not-knowing or being stuck. In this study, the youth workers viewed their not-knowing as traumatic experiences, leading them to question the preparation they received for their profession. They also questioned

their professional and personal self-identities. Although some view youth workers as engaged in a profession, the preparation for youth workers varies across settings. There is no standardized curriculum to prepare youth workers, nor are there national standardized board exams to pass. There is not a formal code of ethics for the youth worker profession and no documents on professional core values for youth workers. As a result, one cannot assume that the burden felt by youth workers when in situations of not-knowing is the same burden felt by physical therapists.

The phenomenon I call not-knowing may have been explored in the literature but may be named differently, such as the average person *finding him- or herself in a predicament* (Thompson, 2007). While understanding this phenomenon is certainly worthwhile, one cannot assume that not-knowing for the physical therapist professional is the same phenomenon as the average person being in a predicament. The physical therapist, for example, is bound by heightened ethical and moral codes of behavior specified for members of that profession, something not true of the average person. Furthermore, the public looks to these professionals to act virtuously, in an ethical manner. In short, the essence of being in a predicament for the average person lacks the specificity that inheres in the professional identity and implied obligations of a professional physical therapist.

Hence, studying physical therapists' experiences of not-knowing merits further research. Pursuing such research contributes a discussion of a hitherto underresearched topic to the general physical therapy literature. More specifically, it addresses an aspect of physical therapists' experiences in the context of ISL work, yielding a deeper understanding of this newly established field for physical therapist professionals. This

specific benefit is particularly significant, since, as noted earlier, the new opportunities for physical therapists to do ISL work provide an opportunity for such professionals to experience specific moments of uncertainty or not-knowing, despite their successful practices in their professional work in the United States. Although moments of not-knowing occur during work done the United States, when these moments occurred in the context of the ISL work setting, the physical therapists experienced a heightened sense of self. The tension between being a competent and ethical physical therapist and feeling unable to respond triggered an especially compelling conflict of identity.

Thus, this study focuses on the international professional setting where physical therapists moved from having a sense of professional competence—of knowing—to one of not-knowing, wherein at times they questioned their expertise. Describing how these physical therapist professionals managed the disorienting dilemma faced by not-knowing in an international setting provides others with a rich opportunity to ponder more deeply how professional physical therapists begin their journeys into expert practice and integrate global clinical competence into the practice of their profession.

Summary

In this chapter, I have provided a general description of physical therapists and the challenges faced when engaging in the new setting of ISL work. Not-knowing is one phenomenon physical therapists encountered in ISL work. I have also illustrated the gap in the literature regarding the phenomenon of not knowing for the average person or youth workers may not hold the same gravity as the lived experiences of physical therapists engaged in ISL work. In Chapter Two, I discuss the phenomenon of not-

knowing, or being stuck, in detail and address what it might mean to physical therapists involved in ISL work.

Chapter Two

The Phenomenon: Not-Knowing

Physical therapists who travel to international sites for service-learning work often find themselves thrown into situations in which they are not fully aware of how to react. While language differences can present barriers, more importantly, therapists often must face the fact that their ordinary, familiar social rules may no longer apply. Furthermore, the new international context may alter the familiar experience of performing one's professional duties. These situations may even end up being paralyzing moments. Yet relationally, physical therapists must move forward into action for the wellbeing of their patients or clients. When physical therapists encounter problems in the unfamiliar setting of ISL work, their tools for dealing with everyday life and practice can become useless and weighty.

Author Wu (n.d., http://www.phenomoneolgyonline.cm/articles/wu.html) suggests that, as foreigners, people can encounter everything as new, affording them the opportunity to step back and reflect on their new situations. Wu states that in such encounters, "The tailored-fit relationship between people's actions and their situations no longer exists" (¶8). Indeed, these may amount to moments of not knowing what to do or how to act, moments that may allow time for self-reflection. In addition to allowing for self-reflection, this time can also create a moment of self-conflict, however. For physical therapist professionals this conflict can emerge as a conflict of professional identity, of the person seeing him or herself as a professional who usually knows what to do and who should know what to do, but who does not know how to respond in a particular current

situation. Consequently, not-knowing holds serious implications for those who are supposed to know. This chapter explores the phenomenon of not-knowing and its implication for physical therapists professionals.

Van Manen (1997) suggests that "being attentive to the etymological origins of words may sometimes put us in touch with an original form of life where the terms still had living ties to the lived experiences from which they originally sprang" (p. 59). Thus, etymology, or studying the origins and the meaning of words, is a helpful strategy in pursuing phenomenological analysis and interpretation (Compact Online Oxford English Dictionary, n.d.; van Manen, 1997). Indeed, as van Manen (1997) further suggests, "This search of etymological sources can be an important (but often neglected) aspect of phenomenological 'data collecting'" (p. 61). Understanding the meaning of the terms *knowing* and *not-knowing* may help us understand why knowing is so important to a professional physical therapist and why not-knowing is such a challenge. We may hence gain an understanding of how moments of not-knowing may produce dissonance or self-doubt regarding professional identity when situated in ISL work settings.

Knowing and Not-Knowing

According to the compact Oxford online dictionary (http://www.askoxford.com/concise_oed/know?view=uk), as a verb, *know* implies several things. To know is to have knowledge of something through observation, inquiry, or information. It implies that one be absolutely sure of something. Knowing suggests that one be familiar or friendly with another to the point of having good command of a subject or a language. Finally, to know suggests that one have personal experience regarding something. *Recognize* and *identify* are two synonyms suggested for the verb to

know. Furthermore, the compact Oxford online dictionary (http://www.askoxford.com) states the adjective form, *knowing*, implies that "one has secret knowledge," while the noun form implies that one is in "the state of being aware or informed."

The Merriam-Webster online dictionary (http://www.merriam-webster.com) states that the verb *to know* comes from the Middle English word *cnāwan*, which is akin to the Old High German *bichnāan*, meaning to recognize. The Latin words *gnoscere* and *noscere*, as well as the Greek term *gignōskein*, mean *to come to know*. Here, the verb *to know* is considered a transitive verb. This definition suggests that knowing is a process, whereas to know something is "to perceive directly; to recognize the nature of or discern; to recognize the same as something previously known; or to have experience of [something]" (Merriam-Webster Online Dictionary). *To discern* means to see, recognize, or understand something that is not clear (Merriam-Webster Online Dictionary). Finally, *to know* is "to have understanding of" (Merriam-Webster Online Dictionary).

Knowing something or someone, including oneself, implies that one makes sense of that thing, person, and/or one's situation with good command through personal experience. The Merriam-Webster Online Dictionary defines the word *not* as "express[ing] negation, prohibition, denial, or refusal." Hence, *not-knowing*, then, entails the negation of knowing. Thus, not-knowing implies that one does not have fully clear or certain mental apprehension, that one is not fully informed, and that one is not in full possession of specialized information.

When experiencing not-knowing in an international setting, physical therapists may not only fail to know the cultural demands of the situation and the proper professional response to a physical therapy challenge, but they may not know or

recognize their roles as professionals in the ISL work setting. The professional physical therapists in this study indeed had demonstrated expertise in their physical therapy practices in their home countries. In their international work, however, they faced situations in which they could not function as efficiently as they might have back home in their familiar surroundings, surroundings with which and in which they were comfortable. Although admitting to having moments of not-knowing in their practices in the United States, my participants commented on how their moments of not-knowing when in foreign countries seemed so much more difficult to face, manage, and overcome. Many other physical therapists in ISL settings may face similar crises of not-knowing and may also experience the related conflicts of self-identity.

Author Wu (http://www.phenomenologyonline.com/articles/wu.html) explains what not-knowing as a foreigner can entail:

> The process of inner conflict may lead to great distress. It is not simply that my ears hate my mouth, or my mouth hates my eyes. The inner conflict inhabits my entire being. It makes me feel that my own "self" is falling apart. Now I have two "me's" inside myself. A "me" with whom I am familiar and with whom I feel connected. This is the "me" I enjoyed and was proud of. . . . The other "me" is a stranger. It is like a distorted figure which always appears whenever I am in the darkness of "foreignness." I cannot accept it since I do not like to. I cannot reject it either since it is part of my own self. My old half hates my newly discovered half. It is also the newly acquired value that fights against the old value in my old half. To regain peace and confidence, a re-organization or

> reshaping of self is needed. This process is threatening, as one has to alter one's own identity, in order to accept this reincarnation. (¶ 15/ p.4)

The physical therapists in this study were foreigners in new lands. Subsequently, they sought to respond to their environments and to interrogate their self-identities as therapists. Their work routines changed, their professional identities were challenged, and their identities required reshaping. Wu suggests that foreigners need to understand themselves and to know who they are by figuring out what image they have left in the eyes of those with whom they are engaging in their everyday activities. Physical therapists must face the fact that they hold different, little, or no status as members of the new ISL work environment. This altered status can compound the unease a therapist might feel when trying to make good judgments on behalf of another.

Understanding Professional Identity

For physical therapists in ISL work settings, managing one's professional identity, as well as the ethical responsibilities that the profession requires, are at the core of the tensions that arise in moments of not-knowing. Concepts of professional duty and responsibility from a physical therapist's home country may be interpreted with different role expectations in a foreign country. What is a professional and what does belonging to a profession mean? The word *profession* is "a paid occupation, especially one involving training in and a formal qualification" (Oxford Online Dictionary). The Online Medical Dictionary states that a profession is "a calling or vocation requiring specialized knowledge, methods and skills" (Medical Dictionary Online). Furthermore, belonging to a profession means accepting specific responsibilities that partially define any particular profession. For example, members of a profession continuously work to enlarge its body

of knowledge, function autonomously in the formulation of policy, and maintain high standards of achievement and conduct (Medical Dictionary Online; APTA, 2008a). Maintaining a code of ethics is also a way a community of professionals establishes expected behavior; such a code may include core values of pursuing lifelong learning, placing service above personal gain, and being committed to human and social welfare (Medical Dictionary Online; APTA, 2003b).

The literature on professional identity provides a foundation for professional roles and ethical behavior of physical therapists (Jensen, Gwyer, Hack, & Shepard, 2007; Merriam, Caffarella, & Baumgartner, 2007; Schön, 1983). According to Schön (1983), professional identity rests upon the perceived ability of professionals to systematically and effectively respond to situations within their professional realm. In fact, the knowledge and ability with which professionals respond defines a profession itself. Jensen, et al. (2007) suggest that professional education should not only be concerned with "novice development toward professional competence and the development of expertise" (p. 22). Members of a profession must also demonstrate that they and their professional colleagues remain competent over time. Professional education and practice, then, must consider the interrelationship between consistent competence, novice development, and expertise (Jensen, et al., 2007).

In particular, Norman (1985) proposed that clinical skills, knowledge and understanding, interpersonal skills, problem solving and clinical judgment, and technical skills are all a part of professional competence in medicine. Given this complex portrait of what it means to be a medical professional, physical therapists who experience not-knowing in a work setting may question their worthiness to belong to a profession in

which sound clinical judgment and technical skills are linked to competence. Others may simply see their moments of not-knowing as steps in the process of clinical decision-making.

Epstein and Hundert (2002) suggest that professional competence is built on a foundation of basic clinical skills and scientific knowledge, but that it also extends into the realm of moral development. They further argue that, although professional competence is built on cognition and technical skills, the essence of a professional is found in a person's integrative skills and behaviors involving context, relationship, affective behaviors, moral meaning making, and habits of the mind. Moments of not-knowing occur in therapist-patient or therapist-client relationships and work settings beyond the time spent in one's formal academic preparation. It is essential, then, that a discussion of the topic of professional identity be included in a description of moments of not-knowing and what it means to experience not-knowing for practicing ISL physical therapists. Despite moments of self-doubt, experiences of not-knowing may prove to be opportunities for life-long learning.

A Calling, a Vocation?

The issue of vocation is also relevant to a discussion of not-knowing for the physical therapist professional. When considered in this circumstance, the idea of vocation is understood in terms of a calling or purpose in life as opposed to simply having a job or occupation to pass time or earn a living. The intensity of a potential identity crisis rises when one takes on the belief that one has been called to a profession. Raatikainen (1997) described calling as a "deep internal desire to choose a task or profession which a person experiences as valuable and considers her own" (p. 1111). In

this sense, physical therapists who experience their work as a vocation or calling feel called to their profession because of the moral element described by Jensen, et al. (2007). These physical therapists identify themselves with the profession, internalizing its values, and consider the profession central to their sense of self and as essential to the profession. Being called to the profession separates physical therapists from other service providers in that improving function requires an ability to connect with patients on a deeper level. Physical therapists must understand the personal and environmental contexts of their patients' lives in order to develop meaningful care plans to improve function according to Jensen, et al. (2007).

When considering the deep relationship between a physical therapist and his or her calling to the profession, the experience of not-knowing represents not only a conflict in personal identity, but also a crisis of vocation or calling manifested in self-doubt, which thus intensifies the experience of not-knowing. When one's purpose appears unattainable, as it can in moments of not-knowing, what happens to one's sense of being called to the profession and one's personal and professional justification? As this question implies, the momentary vocational crisis during a moment of not-knowing for physical therapists during ISL work has enormous implications for ethical practice and self-identity. Therefore, not-knowing holds the potential to precipitate a professional and vocational crisis for physical therapist professionals engaged in ISL work.

Physical therapists hold themselves ethically responsible for their professional conduct in ways similar to physicians and nurses. In taking on their professional roles, many physical therapists accept the implied ethical responsibilities to respond competently and effectively to any situation presented to them in the course of their work

(Jensen, et al., 2007). If one's identity revolves around the ability to effectively develop interventions based on specialized knowledge, the weight of the realization that one is unable to develop such an intervention may therefore be especially heavy. Understanding their place in the profession and the moral implications of working with patients in the ISL setting poses a dilemma for physical therapists when they cannot fulfill their ethical obligations to respond in that setting. Although understanding the moral and ethical components of professional identity does not specifically answer my research question, these components do provide a framework for physical therapists' experiences of themselves in moments of not-knowing.

Clinical Decision-Making and Action: Improvisation

Physical therapists work in a variety of settings and hold a specialized body of knowledge they draw on in their professional practice and action. Schön (1983) identified that many professionals generate competent and effective responses despite varied situations and circumstances. Validating and expanding on this claim, Lyneham, Parkinson, and Denholm (2008) suggested that experienced emergency nurses, for example, make critical decisions in relatively chaotic and changing situations, and they do so in an intuitive manner; they may even have difficulty describing how they know what to do in fast-paced emergency situations. The hallmark of professional practice, however, is that professionals are able to generalize their practice from situation to situation (Schön, 1983). Yet this does not discount the professionalism and value of intuitive responses. According to Schön (1983), another factor in professional development is precisely the ability, in professional practice, of individuals to combine knowledge-in-action with reflection-in-action. Professionals skilled in this way reflect

and draw on their lived experiences, recalling strategies via reflection-in-action to help them sort through what to do when experiencing not-knowing, thus yielding knowledge-in-action. For physical therapists in the ISL setting, the process of reflection in yielding knowledge-action may get hung up. Perhaps the transition from reflection to knowledge-action may be so fraught with anxiety that it is not always a smooth or comfortable process. The importance of knowing what to do as a professional may therefore be heightened in the conflict of not-knowing in an ISL setting.

Much of the focus on professional behavior for physical therapists in the United States has been defined by the APTA's Code of Ethics (2008a, 2009b), Core Values (2003b), Guide to Practice (2003a), and the APTA's Normative Model of Practice (2004). These documents provide the roadmap for professional behavior or rules of engagement. Indeed, a new code of ethics for physical therapist professionals will become effective in the summer of 2010. This new document was written to encompass the expanded settings in which physical therapists now engage as clinicians, researchers, educators, consultants, and administrators (Kirsch, 2009a, 2009b). Professional documents may not hold universal truth for practice across national borders. How one thinks, knows, or acts is highly dependent on the context of the setting in which professionals practice and the problems or dilemmas they face (Edwards & Jones, 2007; Epstein & Hundert, 2002). The international setting may provide a disorienting dilemma for physical therapists and challenge how they are able to function (Mezirow, 2000). These disorienting moments of not-knowing in an international setting may contribute to the pressure a physical therapist feels during moments of not-knowing where a code of ethics may hold universal truth. The new version of the code of ethics means to address

an expanded group of situations, yet it may be inadequate or not sufficiently guiding for physical therapists in ISL work. The knowledge that these therapists lack is often technical knowledge related to treatment, not just moral knowledge or knowledge about how to settle ethical dilemmas. So the failure of the code of ethics wouldn't be able to account for all instances of not-knowing.

Elstein, Shulman, and Sprafka (1978) have written about the clinical reasoning among physicians when faced with having to make decisions outside of their areas of expertise. Although the physicians in this study had not crossed international borders, they crossed the borders of comfort and familiarity in what they knew, and have traveled into unfamiliar territory outside their areas of professional expertise. This study showed that expert physicians often resorted to more novice-like strategies of clinical reasoning, using deductive reasoning as opposed to their more usual expert model of inductive reasoning and pattern recognition. This suggests, as Schön (1983) explicitly noted, that moments of not-knowing affect the thinking used in professional practice. Further, it affects the self-identity one assumes as a result of the education and socialization process into a chosen profession (Huber, 2003; Jensen, Gwyer, Hack, & Shepard, 2007).

In fact, during moments of not-knowing, Thompson (2007) suggests that people forfeit some of their pre-determined knowledge in exchange for knowledge of the moment as they make a choice for a possible plan of action. She further suggests that in these moments of not-knowing people actually find themselves. She writes, "We experience a self-revelation as . . . who we are is revealed and discovered" (Thompson, p. 109). This moment of not-knowing may actually provide a rich learning opportunity, one in which, despite uncertainty, people gain a sense of knowing or confidence in

themselves. What can this moment teach a person about his or her authentic self? And what does the not-knowing experience of physical therapists in ISL settings suggest about the phenomenology of human life more generally?

Thomas and Pollio (2002) state, "To achieve a phenomenological understanding of human life, we must consider the way in which human existence is related to its situational context" (p. 16). Heidegger (1962) considers the German term *Dasein*, which is often translated as *Being* (p. 27). He has broken up the word *Dasein* with a hyphen as *Da-sein* which literally means "being-there" (Heidegger, 1962, p. 27). Thomas and Pollio (2002) further challenge us to consider the deeper meaning in this word by considering its two parts: *Da* (there) and *Sein* (being). They believe Heidegger suggests that "Being is never "just" being but always a being in some "there"—that is, always in some place, situation, or context. Dasein is always a being-in-the world, and the hyphens are as important as the words" (Thomas & Pollio, 2002, p. 16). In his book *Phenomenology of Perception*, Merleau-Ponty (1962) reaches a similar conclusion, suggesting that we never just receive stimuli from the world or project our ideas onto the world. Perception is always an exchange or reciprocal transaction between us and our world. He states the following:

> We must therefore recognize as an ultimate fact this open and indefinite power of giving significance—that is, both apprehending and conveying a meaning—by which man transcends himself towards a new form of behavior, or towards other people, or towards his own thought, through his body and his speech. (Merleau-Ponty, 1962, p. 226)

Heidegger (1927/1962) states, “Dasein always understands itself in terms of its existence—in terms of a possibility of itself: to be itself or not itself” (p. 33). The more technical term *Existenz* “is composed of two Latin roots: *ex,* meaning out, and *sistare*, to stand. Hence, the word *ex-sist* means ‘to stand out,’” (Thomas & Pollio, 2002, p. 16). In Heidegger’s context, one’s existence or being-in-the-world is in fact verified and confirmed by the experience of being a figure against a ground (Heidegger, 1927/1962). Thomas and Pollio (2002) suggest that we become aware of our existence when we stand out from our context, from our “there” or *Da* (as in *Dasein*) or from our world (as in being-in-the-world). Considering the international setting in this study as ground, Heidegger’s framework suggests that we ask how participants in this study experienced their professional and moral selves as figures against the ground of the physical places and cultural contexts in which they found themselves during their ISL work. Using Merleau-Ponty’s lens allows us to see a familiar phenomenon of not-knowing in a new light as we enter the embodied lived experiences of professional physical therapists in ISL work who carry the burden of responding knowledgably and behaving virtuously in unfamiliar international contexts in which cultural norms are not always explicit.

Heidegger (1927/1962) also discusses two phenomenological concepts of *thrownness* and *projection* both of which have relevance to this study. He writes, “As something thrown, Dasein has been thrown *into existence*. It exists as an entity which has to be as it is and as it can be” (Heidegger, 1927/1962, p. 321). Heidegger (1927/1962) states that “projection always pertains to the full disclosedness of Being-in-the-world; as potentiality-for-Being” (p. 186). Thomas and Pollio (2002) explain Heidegger’s meanings of these terms this way:

> Each human life comes upon itself in the midst of some situation into which they have been "thrown" beyond the person's wishes. The task of life then becomes one of dealing with our "thrownness" and "projecting" it forward to new situations in which we realize our genuine and unique possibilities. What is important here is that each human life (or *Dasein*) seeks to become more and more responsible for its own being and becoming, and this can only take place if it projects itself into new situations that offer no initial guarantee of meeting personal expectations. Only by taking a chance is it possible for me (or you) to realize a life that is uniquely mine rather than one concerned with meeting the demands and expectations of convention or of other people. (p. 17)

Further, Heidegger (1927/1962) suggests, "It is one thing to give a report in which we tell about *entities*, but another to grasp entities in their *Being"* (p. 63). It is my hope that this phenomenological study will do just that, describe the constituents of *Dasein* or *Being* in a there (an international service-learning setting) for physical therapists engaged in ISL work.

Summary

In this chapter, I have discussed the meanings of knowing and not-knowing as well as the implications of being a foreigner on professional and self-identity. I have also discussed how not-knowing may create a momentary vocational crisis in the ISL setting. Here, physical therapists must make clinical decisions despite being situated in an environment that may cloud a professional's ability to function and know what to do. In Chapter Three, I consider phenomenology as a branch of philosophy and as a methodology. In particular, I turn to the philosophical underpinnings of phenomenology

and the work of Maurice Merleau-Ponty to help illuminate the phenomenon of not-knowing described in the new context of ISL work by physical therapists engaged in that work. I further discuss why the method of phenomenological inquiry is most useful in understanding the meaning of not-knowing from the perspective of the physical therapists involved in ISL work as they reveal themselves in the new context of professional practice in the international setting. Finally, I also describe my own research process, which I used to better understand and describe the experience of not-knowing for physical therapists involved in ISL work.

Chapter Three

Studying the Phenomenon

In this chapter, I discuss phenomenology, some of its philosophical assumptions and claims, and the embodied lens of Maurice Merleau-Ponty (1945/1962). It is my hope that this discussion clarifies the phenomenon of not-knowing as described in the new context of ISL work by physical therapists engaged in that work. Further, I discuss why the methodology of phenomenological inquiry is most useful in understanding the meaning of not-knowing from the perspective of physical therapists involved in ISL work. I hope that the compelling stories shared by my participants later in this study will clearly reveal the essence of the experience of physical therapists' not-knowing in the international setting. I also describe my research process, which entailed one-on-one dialogues between me as researcher and the participants involved in this study.

Phenomenology Explained

What is phenomenology? Philosophers and researchers alike consider this question. In fact, phenomenology is both a branch of philosophy and a way of researching lived experiences. Merleau-Ponty (1945/1962) states the following:

> Phenomenology is the study of essences; and according to it, all problems amount to finding the definitions of essences: the essence of perception, or the essence of consciousness, for example. But phenomenology is also a philosophy which puts essences back into existence, and does not expect to arrive at an understanding of man and the world from any starting point other than that of their 'facticity'. It is a transcendental philosophy . . . . a philosophy which the world is 'already there'

> before reflection begins . . . . It also offers an account of space, time, and the world as we 'live' them. It tries to give a direct description of our expereince as it is without taking account of its psychological origin and the causal explanations which the scientist, the historian or the sociologist may be able to provide. (p. vii)

Yet, phenomenology can be applied to research as well. Indeed, phenomenological research is interpretive research that is qualitative in nature. It seeks a deep understanding of what it means to be human by gaining insightful descriptions of lived experiences. In fact, taking a phenomenological approach offers researchers an opportunity to understand the lived experiences of others. According to van Manen (1997), phenomenology is the study of the lifeworld or our everyday experiences and the meanings we construct from our experiences. Research that takes this understanding of lived experience and of being in the world seriously provides what van Manen (1997) states is "a deeper understanding of the nature or meaning of our everyday experiences" (p. 9).

Yet, in assuming a phenomenological approach, researchers must take care to understand how their own perspectives may color what they see and how they interpret what they see. Research framed by phenomenology seeks to understand a phenomenon within its natural context based on how things appear from the perspective of the humans under study rather than from the perspective of the researcher (Dahlberg, Drew, & Nyström, 2002; Shepard, Jensen, Schmoll, Hack, & Gwyer, 1993; van Manen, 1997). Dahlberg, Drew, and Nyström further state the following:

> Phenomenology seeks the patterns of expereince, the principles, in order to grasp the meaning of the phenomena in question, which is then described as faithfully

> as possible . . . . Phenomenology makes clear that we as researching embodied consciousnesses are participating in the relationship between ourselves and the world that we experience. (p. 95)

As a style of qualitative research, phenomenology arose in Germany during the mid-1800s out of the frustrations of the constraints imposed by positivism on the study human behavior. Edmund Husserl, considered the father of phenomenology, believed that positivism failed to acknowledge multiple ways of knowing or existing (Dahlberg, Drew, & Nyström, 2002). According to Husserl, if positivism were the only way of conducting research, science would be removed from the everyday world and dehumanize society rather than benefit the world (Dahlberg, Drew, & Nyström). Husserl (1970) stated, “Fact-minded sciences make merely fact-minded people . . . . In our vital need—so we are told—this science has nothing to say to us” (p. 6). The crisis of European existence and ultimately all of human existence was one of a fall into hostility and barbarity or a rebirth “from the spirit of philosophy through a heroism of reason” (Husserl, p. 299).

To encourage the rebirth of spirit, phenomenology emerged as a “rigorous new science in which there could be systematic investigation of those things that we take for granted in everyday life” (Thomas & Pollio, 2002, p. 9). Furthermore, this new science would prevent philosophy from reaching crisis levels “of stagnation and insignificance” (Thomas & Pollio, p.9). It would do so by valuing holism, enlargement, and complexity as opposed to reduction, economy, and simplicity (Thomas & Pollio).

Husserl (1970) introduced the idea that we must go to “the things themselves” (p. 2) in order to do justice to everyday experiences. In order to learn about a given

phenomenon, we must be open to it as it reveals itself to us, and we must unlearn many of our preconceived ideas regarding the phenomenon under study (Dahlberg, Drew, & Nyström, 2002; van Manen, 1997). And the intentionality and transcendentality inherent in phenomenology allow us to bring our interests to our research in the proper way. Dahlberg, Drew, and Nyström state the following:

> Lifeworld research that is based on phenomenological philosophy, with its theory of intentionality and notions on transcendentality, makes our relationship with the world of particular importance, and gives us information about how we are connected to the phenomena that we study. (pp. 95–96)

Moran (2000, p. 397) quotes the philosopher Jean Paul Sartre who suggests that as researchers "we would be hunters of meaning, we would speak the truth about the world and about our own lives" (*Situations*, 1947–1976, p. 168).

Two main assumptions underlie phenomenological research. First, humans seek meaning in their lives and second, there are multiple realities that are socially constructed (McClelland, 1995). Polkinghorne (1989) suggests that the aim of phenomenology is to produce clear and accurate descriptions of a particular aspect of human experience, rejecting "the positivists' ideal of a single and unified scientific method that will be able to yield all knowledge" (p. 43). A phenomenological researcher thus attempts to understand a research participant's experience from that participant's perspective and not from the researcher's subjective perspective or some subject-free, objective perspective. In this research project, I attempted to describe and understand how the physical therapists I interviewed experienced moments of not-knowing during ISL work. When developing themes, I aimed to maintain fidelity to the transcripts of the interviews as

spoken by the participants and to use the actual words of the physical therapist participants where possible in order to faithfully capture and convey the essence of their experiences.

Dahlberg, Drew, and Nyström (2002) challenge us to consider whether or not it is possible to generalize results from qualitative studies, specifically phenomenological studies. They conclude, "Results from qualitative studies *can* be generalized and theories *can* be created out of qualitative research" (p. 227, italics in the original). Specifically with regard to phenomenological studies, Dahlberg, Drew, and Nyström (2002) state, "The main assumption behind the idea of generalization and theory development is that the data analysis can be expressed in the form of a general structure, which in phenomenology would be an essence" (p. 227).

So one might ask how phenomenological research is useful to physical therapists. I maintain that drawing on insights from phenomenological writing can help us understand both the essence of the experiences of physical therapists in ISL work acting in patient care, as clinicians, educators, administrators, consultants, and researchers. We may also gain a greater understanding of human experience more generally. McClelland (1995) states, "In reading phenomenological research, we reflect on our own experiences with a phenomenon and create a dialog of sorts with the phenomenological writing" (p. 178). McClelland (1995) further suggests that, through the dialogue we create with phenomenological research, we become more open to the breadth and depth of others' experiences. We also become more open to our own experiences and consequently understand the meanings we have constructed from them more thoroughly. Authors van Manen (1997) and McClelland (1995) further suggest that there is a close link between

knowledge and understanding others that influences the situations or actions we take as professionals. Finally, McClelland (1995) suggests that reading the phenomenological writings of others and conducting our own phenomenological research strengthens our capacity to teach and practice life sensitively.

Phenomenological studies tend to have a common structure. They start with a question about the meaning of a phenomenon. It is also typical that the experiences of relatively few people constitute the focus of a phenomenological study. Furthermore, phenomenological approaches are either descriptive or hermeneutic (Dahlberg, Drew, & Nyström, 2002; van Manen, 1997). Descriptive phenomenology aims to describe the essence of a phenomenon. Hermeneutics, or the interpretation of texts, entails some sort of interpretations of the phenomena under consideration (Dahlberg, Drew, & Nyström, 2002; Polkinghorne, 1989; van Manen, 1997).

In hermeneutic phenomenology, researchers draw upon three sources of possible data: the researcher's personal reflection, reflections of other participants, and sources outside the context, such as poetry, literature, drama, or cinema (Polkinghorne, 1989). Diaries and journals may be included as texts, or researchers may construct texts from interviews, discussions, or other interactions that express lived experiences. Ultimately, the researcher and the research participants, or the researcher and a text, form relationships. The researcher's job is to seek "an authentic telling of the experiences and what they mean from the perspective of the participant" (McClelland, 1995, p. 178).

A phenomenological researcher then draws on the texts to develop themes or constituents in order to express the essence of the experience under study. The phenomenologist subsequently writes and rewrites constituents until the he or she is

satisfied that she or he has described the experience fully, expressing its meanings authentically (McClelland, 1995). It is preferable that this process occur with the participants in order to ensure that an authentic meaning of the experience emerges (McClelland, 1995). For this reason, I chose to conduct two interviews with my participants so that I might ensure any interpretation or description I made was an authentic representation of my participants' experiences.

Phenomenological Terms

Phenomenology "emphasizes the attempt to get to the truth of matters, to describe phenomena, in the broadest sense as whatever appears in the manner in which it appears, that is as it manifests itself to consciousness, to the experience" (Moran, 2000, p. 4). In an effort to get to the matters themselves, I must discuss a few phenomenological terms including the following: *lifeworld, spatiality, corporality, temporality, relationality, essence, Dasein, reduction, bracketing, and imaginative variation*.

Lifeworld. Lifeworld or *Lebenswelt* is "the world in which we are always already living and which furnishes the ground for all cognitive performance and all scientific determination" (Moran, 2000, p. 12). Not only does the lifeworld describe our relationships with people, it also carries with it an historical meaning. The meaning of *lifeworld* according to phenomenology includes four fundamental existential themes: lived space or spatiality, lived body or corporality, lived time or temporality, and human relations or relationality (van Manen, 1997). Phenomenological research attempts to identify and provide a rich description of the elements of an everyday, lived experience from the perspective of those being studied in depth (Blau, Bolus, Carolan, Kramer, Mahoney, Jette, et al., 2002). Moran (2000) suggests that humans are caught up in the

world in which they find themselves thrown and that the lifeworld then provides the ground against which all humans experience or perceive their world as form. This ground becomes that against which human experience is patterned as events constituted by contextual aspects and a person's being in the world (Moran, 2000). Thomas and Pollio (2002) state that "experience, like perception, is always a transaction between us and the world, and both aspects of the transaction are significant" (p. 14).

Spatiality, corporality, temporality, and relationality. As noted, four aspects or fundamental themes constitute lifeworld: lived space or spatiality, lived body or corporality, lived time or temporality, and human relations or relationality (van Manen, 1997). *"Person and world co-construct one another,"* suggest Thomas and Pollio (2002, p. 14, italics in original). How we experience these aspects of our lifeworld are the ways all human beings experience *Dasein*, or being-in-the-world, according to Heidegger (1962). Thomas and Pollio (2002) summarize that these contextual factors in our lives mean that being is never just being, but always a being in some there, which is some place, situation, and context, and that perception is the exchange or transaction between an individual and his or her world. When one finds oneself in a foreign land, lived time, lived space, lived body, and our lived relation to other human beings are altered by the culture and customs of the foreign country (Peace Corps, nd). Consequently, what may be viewed as normal ways of previously living time, space, body, and relations with others may become confusing and disorienting in the new setting of a foreign country.

Essence. Phenomenology maintains that there are essential structures to any human experience and that these structures have a pattern that is unique to each experience (Blau, Bolus, Carolan, Kramer, Mahoney, Jette, et al., 2002; Dahlberg, Drew,

& Nyström, 2002; Polkinghorne, 1989; van Manen, 1997). The term *essence* in phenomenology refers to the essential core that makes something what it is (Dahlberg, Drew, Nyström, 2002; van Manen, 1997). Author van Manen (1997) states that an essence is a "linguistic construction or description of a phenomenon" (p. 39). One might thus say that it is the teasing out of knowledge from the experience. Thomas and Pollio (2002) further state that essences by definition are "patterns of meaning that were universal, unchanging over time, and absolute" (p. 9). An essence then describes the uniqueness of a given experience or thing and is what makes it what it is.

Reduction and bracketing. *Reduction* is a term relating to the way a researcher strives to set aside his or her subjective experience when observing the world (Dahlberg, Drew, & Nyström, 2002). It is a way of removing oneself from what exists for the participant being interviewed in a study. Reduction then refers to the idea that we can be led back to direct and primitive contact with the lifeworld which is experienced as lived meaningfulness (Merleau-Ponty, 1945/1962). Here, Merleau-Ponty suggests the uniqueness of the particular phenomenon to which we are oriented is revealed through wonder, openness, concreteness, universality and flexible rationality (1945/1962). Similarly, Moran (2000) suggests that *bracketing* is a term that describes the strategy of putting aside of "all scientific, philosophical, cultural, and everyday assumptions . . . . in order to focus exclusively on the evidence" (p. 11). Thus, bracketing is how the researcher strives to set aside his or her personal, subjective experience in order to remain open to the participant's description of their experience. It is an intellectual activity in which one tries to put aside theories, as well as one's knowledge and assumptions, about a phenomenon. Gadamer (1960/1995) reminds us about the importance of remaining

open. He writes, "The important thing is to be aware of one's own bias, so that the text can present itself in all its otherness and thus assert its own truth against one's own fore-meanings" (p. 269). The researcher's task thus becomes one of maintaining an open, nonjudgmental attitude when conducting and interpreting interviews text (Thomas & Pollio, 2002). Reduction and bracketing, then, involve acknowledging and putting aside the researcher's presence or biases during the process of conducting phenomenological research.

Imaginative variation. A final strategy of phenomenological research I used in the analysis phase was imaginative variation. It is a process by which a researcher imagines the lived experiences of others in various ways so that the absolute essence of the experience emerges, allowing for the researcher to then speak of the object's or thing's essence or character (Dahlberg, 2002). Moran (2000) explains it this way:

> In order to grasp an essence more clearly, Husserl thought it useful to perform what he called 'imaginative free variation' where we take aspects of our original intuition and substitute parts in a manner which allows the essence to come into view and anything merely contingent to drop away. The whole point of free variation is to open up new aspects of the experience and especially those invariant aspects—aspects which belong to the essence of the experience. . . . Imaginative free variation plays a helpful role in allowing the *eidos* or essence of the phenomenon to manifest itself as the structure of its essential possibilities. (p. 154)

The act of imaginative variation is closely linked to the notions of reduction and bracketing. Indeed, Husserl (1964/1970) suggests that the whole trick to imaginative

variation is to give free rein to the observing eye and yet to bracket references to meaning that go beyond what is given in the seeing of the phenomenon. As researchers, we are to question ourselves about what meaning we give to our observation of a phenomenon. Thomas and Pollio (2002) suggest that in this process, “The researcher ponders not only specific words, but the meaning of those words in the context in which they were uttered and their relationship to the participant’s narrative as a whole” (p. 37). Finally, Gadamer (1960–1995) suggests, “The imaginative productivity is not richest where it is merely free, however, . . . where the understanding’s desire for unity does not so much confine it as suggest incitements to play” (p. 46).

Merleau-Ponty: Holism, Embodiment, and Culture

Merleau-Ponty’s philosophy is an excellent fit for this research project on the experiences of physical therapists because his work addresses holism, embodiment, and culture (Thomas & Pollio, 2002). Holism is a key concept in physical therapy philosophy, given the profession’s emphasis on health and wellness. It is also a crucial concept of the International Classification of Function model (WHO, 2001) currently gaining favor in physical therapy practice internationally (APTA, 2008; WCPF, 2008). The ICF model requires viewing persons as irreducible wholes when describing their health and health-related statuses from biological, personal, and societal perspectives. When considering whether or not disordered function constitutes a disability, this model describes physical and functional disorders, as well as those involving activities and participation, as impairments, limitations, and restrictions, while also considering contextual factors such as the environment and personal factors (WHO, 2001).

The philosophy of Maurice Merleau-Ponty (1945/1962) focuses on perception and involves description of direct experiences of events, objects, and phenomena of the world. And as Thomas and Pollio note, "Unlike thinking and language, which deal with ideas and representations of the world, perception always concerns an ongoing transaction between person and world" (Thomas & Pollio, 2002, p. 14). The aim of Merleau-Ponty's work was to challenge us to return to the world as we expereince it and examine our experience before it is classified by science or rational thought (Thomas & Pollio). Merleau-Ponty advised us to be "astonished by the world, to make direct contact with it, and to see it with open eyes filled with awe and wonder" (Thomas & Pollio, 2002, p. 13).

In Merleau-Ponty's work, embodiment is closely linked to perception and is also an important concept in understanding health (Merleau-Ponty, 1945/1962). The term *embodiment* refers to "experiencing and understanding the world by, and through, the body" (Thomas & Pollio, 2002, p. 12). Merleau-Ponty suggests that this process demands a transformation in a person's very being as he or she learns from the people with whom he or she interacts in the world. Individuals gain new insights from that first-person perspective. Expanding on this idea, Macann (1993) notes, "In learning how to *see*, we learn how to *be,* how to be something other than what we were when we remained blind to the new way of seeing that gives us access to the origin" (p.170).

Moran (2000) concurs with Merleau-Ponty and states that the world is revealed to us in a very special way through our specific sense organs. As such, Moran (2000) suggests the following about Merleau-Ponty:

> One of Merleau-Ponty's most useful methods was to examine cases where our normal assumed relation to the world breaks down. It is failures of the system which reveal most clearly how the system works. These systems, these matrices of habitual action through which we approach the world (PP 104; 121), are not transparent to consciousness and can never be uncovered simply by reflection. We need to study people with malfunctioning systems in order to make manifest the nature of the system, which, when working properly, is invisible. (p. 419)

Further, perception is the primary task of describing the human experience of human life (Thomas & Pollio, 2002). Moran (2000) suggests that philosopher Merleau-Ponty aims to use perception "as a basis for studying complex issues such as the relation of humans to each other in language, culture, and society" (pp. 417-418). Merleau-Ponty's philosophy hence allows us to consider what happens when our normal relations to the world break down through, for example, impairments of the body or others disruptions in functioning. What happens when the body remains intact yet the lifeworld or environment is altered through the cultural context of the ISL work setting? In such situations, the human situation is both finite and ambiguous. A physical therapist's inability to fully process what he or she perceives thus challenges that person to realize things may not be as he or she thinks they should be; the physical therapist involved in ISL activities must work to make sense of the given situation or expereince.

Thomas and Pollio (2002) state that Merleau-Ponty "offered a philosophy of meaning—the meaning that is revealed in real life—where work is done and where human beings live together and enter into dialogue" (p. 12). Since experiences involving perception are transactions between an individual and the world, one might ask what

happens when physical therapists enter and experience the ISL setting, yielding for the therapists a lifeworld that is altered through travel and that is imbued with different cultural meanings? When a physical therapist travels to a new country for ISL work, the world that he or she perceives may be suffused with meanings with which the individual is unfamiliar. Experiences of not-knowing may very well result.

A heightened sense of the four existential parameters of the lifeworld seems to occur during a moment of being stuck and not-knowing during ISL work. The use of phenomenological methods allow me to fully appreciate the lived space (spatiality), lived body (corporality), lived time (temporality), and human relations (relationality) my participants experienced, and using these concepts allowed me to more fully explore this moment of not-knowing during ISL work for physical therapist. I was thus able to explore the following question: What is the essence of not-knowing during ISL work for physical therapist professionals?

Methods, Procedures, and the Research Process: Finding Answers

In trying to gain an understanding of how physical therapists experience moments of not-knowing during ISL work, I had to ensure that the research methodology I used helped to answer the research question. I chose descriptive phenomenology as the method that would best answer my question because it allowed me to examine the phenomenon of not-knowing from the point of view of the physical therapists being studied rather than from my perspective as the researcher. It also allowed me to gain access to an experience as lived by the participants as opposed to my interpretation of that experience. This section describes the research procedures I used in this project.

Bracketing Process

Before beginning to collect data, I conducted a bracketing interview with another researcher who was familiar with phenomenology. The purpose of this bracketing interview was to explore my biases and expectations regarding the phenomenon I was studying. This task was especially important for me since I have lived the experience of not-knowing several times during my own ISL work. I needed to bracket out my personal experiences and expectations so they did not influence my interviews with my participants. The approach used by van Manen (1997) requires a bracketing process before and during the research process to limit bias. Other phenomenological researchers (Polkinghorne, 1989; Thomas & Pollio, 2002) have also recommended the use of bracketing interviews or self-reflection by researchers in order "to help them become aware of and bracket out the presuppositions and assumptions they bring to the investigations" (Polkinghorne, 1989, p.47).

Bracketing is the act of reflection by the researcher on any preconceived beliefs or feelings pertaining to the research topic (Dahlberg, Drew, & Nyström, 2001; Polkinghorne, 1989; Thomas & Pollio, 2002; van Manen, 1997). A bracketing exercise may take the form of an actual interview or a session of journal writing regarding one's biases and beliefs before and possibly after each interview. I benefitted from both a bracketing interview before collecting data and journal writing during the interview process. During the interview phase of my research, these strategies helped me identify and then set aside my assumptions and beliefs regarding to the phenomenon of not-knowing.

Indeed, during both the interviews and data analysis phases of my research, bracketing strategies allowed me to better understand my biases regarding the phenomenon under study and to put aside any preconceived ideas I had of the experience as lived by my participants. Some of my own biases included thinking that not-knowing was a topic others would be willing to share with me and that the phenomenon would be more intense for a person situated in an international setting. Given that knowing what to do is stressed as important in a physical therapist's training, I wondered about the possibility that those who had experienced not-knowing may have felt self-doubt regarding their professional role. I also assumed that many of these physical therapists would be carrying a burden of being seen as an expert in the ILS setting, despite being from other parts of the world. I wondered about how physical therapists in the ISL setting handled their privileged status as a foreigner and the experience of not-knowing. I also wondered if physical therapists would be transformed by the experience of not knowing what to do. Some final assumptions I held were that the moment of not-knowing in an international setting may be complicated by language barriers, isolation, and challenges in seeking answers or resources.

Recruitment

One of the most important things to ensure when recruiting participants to be interviewed about a lived experience is that the participants involved actually have had the experience under investigation. In this case, I sought participants who were physical therapists who had experienced a moment of not knowing what to do during ISL work. While this criterion is necessary, it is not sufficient, however. An important second criterion is that the participants be willing and able to talk about their experiences.

I posted an invitation and recruitment poster on the listserv of the Cross Cultural and International Special Interest Group (CCISIG) of the Health Policy and Administration section of the American Physical Therapy Association (APTA). I posted a second notice on the listserv of the APTA Education Section to ensure that I reached enough potential participants. I also posted recruitment flyers at the Minnesota APTA state conference to let physical therapists know about the study and to provide information so that those interested in the study could contact me. (See Appendix A).

I initially thought that finding participants could be a challenge because of the implications of a professional admitting to not-knowing or being stuck. It was helpful that I had participated in ISL work as a physical therapist. I hoped that my own experience would help participants see me as a safe person with whom to discuss their experiences of not-knowing. After all, I was not their supervisor or the head of an international organization providing employment or volunteer opportunities. I hoped that those interested in participating would see me as a neutral and safe person with whom they could share their stories. I provided my contact information to those who had an interest in participating in the study, or for those who had questions regarding the study. Potential participants contacted me by email or phone. I accepted the first 20 people who volunteered if they met the inclusion criteria listed below.

My participants included 20 licensed physical therapists. Four were men and 16 were women. The ages of my participants ranged from 28 to 65 years. Sixteen of the participants were American, two were Canadian-trained physical therapists, and two were Dutch-trained physical therapists. Before they engaged in ISL work as physical therapists, my participants had been in practice from just over a year to more than 30

years. Finally, my participants had traveled to countries in Europe, Asia, and Australia, as well as Central and South America for ISL work.

Conducting Interviews

I screened volunteers who responded by phone to determine if they indeed had an experience of being stuck or not-knowing what to do while engaged in ISL work and to determine that they met the inclusion criteria of having this experience occur within the last five years. Other inclusion criteria they had to meet included that participants had to be licensed physical therapists and English speakers so that I could understand and identify the nuances of their experiences. The participants could be male or female. During the ISL work, the physical therapists had to have experienced a moment of not-knowing what to do while interacting with others in some way as a physical therapist. Criteria for exclusion included those not having an expereince of not-knowing during ISL work, those who were non-licensed physical therapists, those who did not have an ISL experience, or those whose experience occurred more than five years previous to the interview. Finally, physical therapists were excluded if they did not speak English.

After completing the screening process, my participants chose safe, convenient places and times for the interviews. I met with people either locally in the Minneapolis-St. Paul area, at the APTA Combined Sections Meeting in Las Vegas, Nevada, or at the International Society for Prosthetics and Orthotics (ISPO) Conference in Juan Dolio, Dominican Republic. Each participant was allowed to choose a pseudonym to protect his or her identity. Finally, all the personal and employment information of the physical therapists was kept confidential. Any information regarding ISL community partners was also kept confidential.

For the purpose of this project, I conducted two interviews with each participant. The first interview lasted approximately 60 minutes while the second interview lasted approximately 20 to 30 minutes. The first interviews began with a discussion of the consent form (see Appendix B) and an opportunity for participants to ask me any questions. I assured each participant of his or her right to confidentiality. I also reminded each of his or her right to end the interview at any time, to choose not to answer any questions that made him or her uncomfortable, and to withdraw from the study at any point, even after their interviews were completed, without fear of repercussions. I then began the interview by asking the participant to think of a time when the participant experienced a moment of not-knowing or being stuck while involved in ISL work. (See Appendix C for the interview guide). I probed further as needed; sample probes are listed in the interview guide.

In the first interview, I asked participants to describe a situation in which they experienced moments of not-knowing what to do or being stuck during their ISL work. This first interview was an in-depth, unstructured interview that was conversational in nature and was one in which the participants recalled their experiences. It was conducted in a face-to-face format.

I digitally recorded and then transcribed all interviews using Naturally Speaking software. Interviews were dictated into the Naturally Speaking program as I heard them through headphones from the digital recorder. I then reread the interviews as I listened to the digital recording for a second time. I made corrections if there were errors in the transcript. Each interview was transcribed within 48–72 hours of completing the interview. I hoped that a quick turnaround in transcription of interviews would allow me

to accurately capture as text the essence of the moment of not-knowing as described by the participants.

Because the experience of not-knowing what to do or being stuck might be difficult for some people to talk about, since admitting to it may be felt to illustrate professional failing or incompetence, I was mindful of the challenges participants might face in telling their stories. With that idea in mind, I was conscious of participants' potential emotional discomfort throughout the interviews. In many cases, as noted in my pilot study during the summer of 2008, participants became emotionally connected to the stories they told. I noted how their speech patterns and their body language changed; they laughed, and in some cases they even became teary during interviews. I was attentive to these emotional reactions while conducting the interviews, relying on my background and formal training in physical therapy to assess my participants' abilities to continue with the interviews. I also resorted to strategies described by Rosenblatt (1995) where processual consent was used during the interview to provide participants an opportunity to stop the interview despite signing an informed consent form before the interview or to continue the interview with a less threatening line of dialogue if needed.

It was my hope that participants would enjoy sharing their stories with me. In the cases from my pilot study and this current study, participants mentioned at the end of the interviews that they enjoyed the opportunity to share their stories, and in doing so to relive their experiences again. They were also grateful to express some of the built-up or suppressed emotion surrounding their stories. Many participants in this current study reported that they were not aware of some of the pent up emotions they had been carrying since their experience. They mentioned how helpful they found the interview process in

reconciling those feelings. My participants stated at the end of the interviews that they greatly enjoyed being participants in my study.

Before the second interview, I sent each participant a phenomenological description of his or her experience that I had written after analyzing the first individual interview. The second interviews were also conducted face-to-face, with the exception of three of these follow-up interviews, which were conducted using Skype. During the second interview, I asked participants what they noticed about the descriptions I had written of their experiences. I also asked them if I should change anything that I had written about their experiences. This second interview permitted the participants and me to dialogue about the accuracy of my interpretations, representations, and descriptions of their experiences of not-knowing. In this way, the second interview also served as a resonance check for interpreting the meaning behind each participant's experiences of not-knowing as lived by the individual and described by me.

The suggestions for changes my participants made were more about minute details of their experiences rather than the structure of their experiences. My participants repeatedly commented on how they felt truly heard by me as they reflected on my phenomenological descriptions of their experiences. In an email to me after receiving her phenomenological description and before our second interview, Kuzu wrote, "Wow, is that really me??? In some respects I felt the peace of my experience pour into me after the fast breathing about my moments of not-knowing. WHEW!" (Kuzu, personal correspondence, June 19, 2009). Gary stated the following:

> It seems like you captured it pretty well. I found it just very helpful to be able to tell my story because after we were done I just found out how much I miss doing

> that, you know? Express my feelings and thoughts and attitudes on what was going on so it was just such a very good experience. (Gary, second interview)

In fact, each participant felt I had captured the essence of his or her personal story. A couple of participants suggested only minor changes in details about the location in which or time during which an event occurred. A few participants suggested different wording in passages describing their feelings, which helped clarify questions I had regarding their experiences. For example, one participant corrected her original description of herself as feeling glum to having felt deeply saddened by the reality of seeing so many children in the orphanage in which she was working. Overall, changes to the phenomenological descriptions were minimal, and as the researcher, I graciously accepted them.

Analysis

Several techniques exist for the analysis of phenomenological text. Giorgi (1975, 1997) and Dahlberg, Drew, and Nyström (2002) use a more formal, descriptive orientation, while van Manen (1997) uses a more hermeneutic approach to data analysis. For the purposes of this study, I chose to use descriptive phenomenology. In this way, I remained as close to the written text as possible. In doing so, my participants' voices in the text could speak for themselves, allowing constituents or themes to emerge. Since, the phenomenon of not-knowing for physical therapist during ISL work has not been discussed in the literature, the descriptive approaches of Giorgi (1975, 1997) and Dahlberg, Drew, and Nyström (2002) were selected for the analysis phase of this study. It was my hope to describe the essence or general structure and the constituents of not-knowing during ISL work for physical therapists.

The first step in this phenomenological analysis involved the creation of written texts. The transcripts were organized in a table with three columns, with the text on the left and space for handwritten notes in the two smaller columns on the right so I could make notes regarding constituents and variations of those constituents. Using double spacing between questions and arranging pages in landscape format maximized the amount of text and hand-written notation space allowed per page. The two columns on the right allowed me to make notes on the constituents and variations of constituents that emerged from the text of the interview. This process was completed for all 20 interview transcripts and resulted in approximately 330 pages of interview text.

Individual (vertical) analysis. I began the individual participant or vertical text analysis by using a "tripartite structure . . . described as a movement between whole-parts-whole," according to Dahlberg, Drew, and Nyström (2002, p. 185). In this process "it is imperative that each part is understood in terms of the whole, but also that the whole is understood in terms of its parts . . . . to understand the whole in terms of the detail and the detail in terms of the whole is a methodological principle that takes research into an art of understanding" (Dahlberg, Drew, & Nyström, 2002, p. 186). In this way, the expressions of the participants were transformed and reconstructed into the general language of the physical therapy discipline, with a focus on the phenomenon under examination (Dahlberg, Drew, & Nyström, 2002).

I read each interview at least twice so that I become familiar with the overall content and tone of the story, the phrases used by the participants, and the general feeling of each interview. During a third reading of the interviews, I took notes on the main segments of the interview, underlining or highlighting descriptive words or key phrases

that I then noted in the box next to the text as meaning units or themes (Dahlberg, Drew, & Nyström, 2002; Giorgi, 1975, 1997). In the second box to the right of the text I noted variations on the main themes. Finally, I reread the interview and my notes together in an attempt to ensure that my notes were reflective of both the tone and the significant sections of text that emerged as illustrative of the experience of the each participant's moment of not-knowing.

From the text of each interview, I developed a phenomenological description for each participant. The descriptions were composed of a general summary of the participant's experience, a thematic summary of the themes I saw emerge from the preliminary analysis, and general notes or key phrases that might fit or contrast with other participants' descriptions. These descriptions served to summarize the interview and provided a preliminary dialogue across interviews for the horizontal analysis I needed in order to determine a common description of not-knowing for physical therapists involved in ISL work. I attempted to use the participants' own language when possible. These descriptions provided me with a narrative to send back to each participant as a resonance check, which served as the topic of discussion in our second interview.

The participants themselves were then directly involved in the last stage of the individual or vertical analysis. After returning to the respective participants via email the phenomenological descriptions I had generated, I asked each participant to review the description for resonance with their lived experience as described by me. In this second interview with the participants, I inquired about whether my description matched the way they lived the experiences of not-knowing. I also asked each participant if I had misunderstood or misrepresented anything in the description. According to Brown

(1989), resonance of this sort is a crucial hallmark of good interpretive research. Without the participants' ultimate approval, any of my descriptions or interpretations would be inadequate and would fail to demonstrate fidelity to the participants' experiences.

My participants also received my response to the common description of the structure of the experience quite well. One participant, Andrew, stated, "I think your themes are quite descriptive of my experiences." Another replied, "Wow! I am so impressed! I think your interpretation is exactly how I felt. I would not change a thing." Jillian stated, "This is awesome! You really did a great job putting this together." Isabel reported, "You did a good job capturing my feeling and my situation of not-knowing." As stated above, there were minimal changes in the individual phenomenological descriptions.

Thematic (horizontal) analysis. Finally, I compared constituents across all interviews to determine if they were similar and developed the final common description of physical therapists' not-knowing while engaged in ISL work. I then used the variety among descriptions of the phenomenon of not-knowing provided by the participants to seek the essence of the general structure of the data (Dahlberg, Drew, & Nyström, 2002). With an awareness of the whole, I organized the parts in order to see and understand patterns or clusters of meaning that emerged from the data. As I looked at the data and reflected on the meanings, similarities, and differences in participants' narratives, the essence of the experience emerged; I grouped together common meanings so that a meaningful pattern or general structure of the experience emerged (Dahlberg, Drew, & Nyström, 2002).

Informed by Barritt, Beekman, Bleeker, and Mulderij (1983), I developed an analysis table to assist in identifying themes. With one column per participant and one row per theme, I plotted the significant themes or constituents for each vertical analysis. Looking horizontally across the table, I identified themes or constituents that appeared to resonate consistently, even if they appeared in varied forms across the participants' descriptions. The table also helped facilitate the back-and-forth movement between the descriptive and interpretive elements of phenomenological research, balancing the participants' descriptions of their experiences with my own descriptions of their meaning.

The next step was to compile a common description of the structure of the experience of not-knowing from the experiences shared by my participants. In addition to finding the common constituents and key phrases from the interview texts, I searched for variations on the dominant constituents. Use of variation refers to the diversity in how a constituent is revealed or manifested. Diversity in themes is better thought of as subtleties in than alternatives to the constituents, as they demonstrate the depth of a constituent rather than deviations from it (Anderson Nathe, 2005). I then used imaginative variation to determine if each theme was essential to the experience of not-knowing. Dahlberg, Drew, and Nyström (2001) state that imaginative variation is a process of analysis where others' lived experiences are imagined in various ways so that the absolute essence of the experience emerges. If I determined that the theme was essential, I considered it a constituent or absolute part of the structure of the experience. If through this process I determined that a constituent was not essential to the common structure, I excluded it from the common structure of the experience. Dahlberg, Drew, and Nyström (2002) suggest that in this process "the researcher can further use her/his

own conscious ability to imagine or intuit further variations, in order to clearly see the essence or general structure" (p. 191). I then wrote the preliminary draft of my description or structure of how physical therapists experience moments of not-knowing during ISL work.

Table 3.1 includes my initial ideas on constituents regarding the moment of not-knowing for physical therapists involved in ISL work.

Table 3.1

Initial Ideas About Constituents

Constituents	**Key Phrases**
Paralysis by Analysis	Deer in headlights Oh, my God! Breathlessness
Facing Limitations	Something is not right . . . A loss of control! What do I do?
Fear	Being seen as an imposter Failure Hopelessness/despair
Ugly American	Holding privilege Expert views Expectations for change
Questioning One's Vocation	Self-doubt Is doing my best enough? Carrying a burden for solutions
Strategizing	Rules of engagement Stepping away to think Improvisation
Illumination & Reflection	Seeing possibilities clearly New ways of knowing

Typically, during a researcher's process of imaginative variation, themes that initially appear to be essential often are later found to be variations on larger themes (Barritt, Beekman, Bleeker, & Mulderij, 1983). Dahlberg, Drew, and Nyström (2002) concur:

> It could happen, for example, that the researcher has worked out a preliminary pattern of understanding, but then makes new discoveries when analyzing a rich material. The new discoveries must influence the previous description. Sometimes a preliminary result must be completely destroyed, and sometimes it is sufficient to make some minor adjustments. The main thing is to keep one's mind open through the whole process and to be sensitive to nuances and changes in meaning. The meaning of minor pieces of the text sometimes change the whole of something that is developing, just as the whole of the text affects the meaning of the little piece. (p. 192)

I found that having patience with this system, maintaining an open mind, and holding these elements in conversation with dominant themes of the whole were essential in developing my final description of the experience of not-knowing for physical therapists during ISL work.

Through this process, I collapsed several constituents into others. The preliminary themes of "Paralysis by Analysis," and "Facing Limitations," were collapsed into the initial constituent of "Facing Limitations—Surprise or Shock: Oh, My God!" The constituent "Strategizing" remained as the second final constituent but was renamed "Strategizing and Improvising: On the Fly by the Seat of My Pants." The initial constituent "Fear" (of being seen as an imposter) was combined with the constituents "Questioning One's Vocation" and "Ugly American" to form the new third final constituent, "Professional Identity and Self-Doubt: I Feel Like an Imposter!" The final constituent, "Illumination and Reflection," was also renamed "Illumination and Clarity:

When the Light Bulb Turned On!" Table 2 presents the final list of constituents of the general structure for the experience of not-knowing from my data.

Table 3.2

Final Constituents of the General Structure of Not-Knowing

Final Constituents
Facing Limitations—Surprise or Shock: Oh, My God!
Strategizing and Improvising: On the Fly by the Seat of My Pants
Professional Identity and Self-Doubt: I Feel Like an Imposter!
Illumination and Clarity: When the Light Bulb Turned On!

Resonance Rounds

In order to ensure that the common (horizontal) description was both believable and illustrated the constituents of the experience of not-knowing, I conducted three final resonance rounds on my universal description, as Thomas and Pollio (2002) suggest. I sent the common description of the experience of not-knowing to the participants in the study to determine if my common description resonated well with them. As a second resonance round, I also sent the common description to 10 physical therapist colleagues in the field who had been involved in professional practice and in ISL work; however, these physical therapists did not participate in the study. I listened to the feedback I received and incorporated any additional clarifications or suggestions into the final common description; I present this material in the next chapter.

An educator and administrator of ISL work for DPT students stated, "What I read definitely makes sense and resonates." Another physical therapist educator and clinical director of education who had also participated in ISL work wrote, "I love, love, love your descriptions. If it is ok with you, could I share it with students who are going internationally on internships?" (LJ, Personal communication, November 12, 2009). Another physical therapist who had participated in ISL work and is now a new professor who coordinates others' experiences stated this in an email to me:

> Wow—powerful stuff! I definitely can relate!! The one theme that you touched on but that I remember feeling so strongly and still feel now that I am a professor is: SELF-DOUBT! Do I really deserve to be seen as the expert, am I in over my head, do I really deserve to be here??? (PC, Personal communication, November 2, 2009)

An owner of a pediatrics physical therapy business who encourages her employees to participate in ISL work without losing compensation or vacation time stated the following:

> That all really resonates with me. It was actually very reassuring to read through your notes, and recognize that others find themselves in a muddle at times when doing service-work. This awareness I think will already help our future endeavours as I think I'll have greater confidence to make changes when something isn't working. (IA, Personal communication, November 13, 2009)

A provider for ISL experiences wrote this:

> With regards to "more typical" dilemmas, I think you've got most of it. One area where I think I might diverge from the study's participants relates to the type of

> situation and the position I've been in. The dilemmas that I've found the toughest to deal with have been ones where I was not a short-term visiting expert dealing with a clinical issue (which is what I see when I read this account) but rather a medium-term employee (onsite for 1 year) facing organizational issues. In these cases I wasn't seen as an authority or expert, but rather a meddlesome inconvenience that needed to be discredited or silenced. (CS, Personal communication, November 6, 2009)

Finally, I also asked eight other allied health care professionals, such as physicians, nurses, occupational therapists, and prosthetists, who had been engaged with physical therapists in ISL work about their thoughts on my description of not-knowing during ISL work. I asked these colleagues if the description was realistic and what constituents they could resonate with in the description, despite their not being physical therapists. In this manner, I was able to conduct imaginative variation with other health care professionals who had experiences of not-knowing during ISL work to determine if the general structure of the expereince appeared to be well described and believable. The results of this procedure indicate that the description was well received. One physician wrote in an email, "Sorry for the delay in responding here. How exciting! Was fun to read through your research! I don't have anything specific to add at the moment" (EJ, Personal communication, December, 3, 2009).

A prosthetist shared in a phone call, "I can totally relate to your description of not-knowing even though I am not a PT. It is all about having to face things out of your control when in another country" (BC, Personal communication, December 1, 2009). A nursing faculty member who had engaged in international service work replied this way:

> As far as the stress of feeling like an imposter, I can clearly relate. There is so much self-doubt when I find myself in charge of the group or I am with my patients and things go out of control. It is hard to know everything. (MG, Personal communication, October 30, 2009)

An occupational therapist replied to me with a phone message, saying this:

> Yes, this explanation definitely resonates with me. I have traveled all over South America and still have those feelings even though I am an experienced traveler and professional who is involved in international service-learning work. (BK, Personal communication, November 1, 2009)

It was important to include both participants and others who did not participate in the study but who had experience with ISL work in my resonance rounds because credibility, trustworthiness, and legitimacy are established not simply by the researcher, but by the community to which research claims are made (Polkinghorne, 1989). One concern about working with participants in a study is the challenge of describing what they are telling us about their experiences. As Thomas and Pollio note, "The person to whom we are talking is the expert in his/her experience; we are there to learn about it from him or her" (Thomas & Pollio, 2000, p. 21). Merleau-Ponty (1973) further points out our research participant "is able to get across to me inasmuch as I am . . . capable of allowing myself to be led by the flow of the talk toward a new state of knowledge" (p.143). I hoped my description of not-knowing would be clear to others. It appears my description was indeed clear to others.

Thomas and Pollio (2002) suggest that seeking resonance among participants and others who have had similar experiences is an important aspect of research. Researchers

need to be sure that they correctly interpret what they have been told, and I took this mandate seriously. However, Thomas and Pollio (2002) offer this caution:

> We cannot "lose ourselves" and become the other person. Rather, we are who we are, just as the person being interviewed is who he or she is, and the best we can do is mediate between the two of us in the form of a meaningful conversation. One way to get to such a conversation is to recognize that dialogue works best when the conversational partners concentrate on content not personalities. Because every conversation is "about something," our job is not to look *at* the other person as an object of concern, but *with* him or her at what is being talked about . . . . This process of grasping the core topic allows us to be taken over by it and thereby to come to see the world from the developing and joint perspective of the other person and of ourselves. (p. 23)

The discussion I had with, and feedback I received from, both participants and non-participants who had an ISL work experience about the description I developed thus allowed me to conduct resonance rounds to check the validity of my final common description of the general structure of not-knowing. The overwhelming response was that my description did indeed capture the essence of the experience of not-knowing.

Methodological Rigor in Qualitative Research

Methodological rigor is as important in phenomenology as in other forms of qualitative or quantitative research. Because the aim of phenomenological research is to find meaning and understanding, as opposed to causality and prediction, the criteria to evaluate the rigor of this type of research is slightly different than that used by those with a positivistic view of the world (Thomas & Pollio, 2002). Colaizzi (1978) suggests that

objectivity from a phenomenological perspective is recast or defined as fidelity to the phenomenon as it appears. Thomas and Pollio (2002) state that the researcher must consider questions of methodology and experiential issues by asking whether the methods used were rigorous and appropriate to the research topic. I believe that the phenomenological methods used in this study were an excellent fit for my research question.

Thomas and Pollio (2002) further state that validity, another important part of methodological rigor, is determined in phenomenological studies when one answers the question of whether one has investigated what one wished to investigate. Polkinghorne (1989) suggests that validity is inspired through the confidence found in the persuasiveness of the argument in support of the phenomenon. Polkinghorne (1989) further states, “the degree of validity of the findings of a phenomenological research project, then, depends on the power of its presentation to convince the reader that its findings are accurate” (p. 57).

In phenomenological research the idea of validity is concerned with whether the “structural description of the phenomenon provides an accurate portrait of the common features and structural connections that are manifest in the examples collected” (Polkinghorne, 1989, p.57). Polkinghorne also states, “If findings lack credibility, trustworthiness, or legitimacy, they are not valid” (2003b, p. 125). In other words, “validating a knowledge claim is an interactive process between the person making the knowledge claim and the members of the community to which the claim is proposed” (Polkinghorne, 2003a, p. 24). In phenomenology we are also concerned with whether or not the interviewer influenced the contents of the descriptions in such a way that they do

not truly represent the subjects' actual experiences. It appears from the resonance rounds conducted with the participants as well as with other physical therapists and health care providers who have had ISL work experiences that my description indeed represented their experiences of not-knowing while on international assignment. The criteria of validity were indeed met in this study.

Individual bias in interpretation may also be a limitation in terms of how behavior is described or interpreted. Words can be powerful as descriptors, but they can also bias the study (Briggs, 1086; Bucholtz, 2000; Devault, 1990; West, 1996). In this study, the kinship the participants felt toward the profession of physical therapy appeared to decrease the problem of their limiting or censoring the information that was shared with me. In this sense, rapport building with the participants was helped by the fact that both the participants and investigator were physical therapists. Further, our common knowledge as physical therapists who had participated in ISL work, helped establish rapport so that the participants did not feel compelled to share only parts of their stories with me. In fact, they were very open regarding the uncomfortable details of their experiences.

My having to interpret the participants' experiences potentially posed more of a challenge with respect to bias, yet my use of bracketing exercises helped establish credibility. So, too, did the resonance checks that I conducted during the second interview; using this means my participants and I discussed the descriptions that I had created of their experiences. As noted earlier, I did a second resonance check after I completed the final common description from the horizontal analysis for each theme that emerged; I shared this description with the participants and other physical therapy

colleagues who did not participate in the study to determine if the description was believable or feasible. I also shared the description with other health care colleagues including physicians, occupational therapists, registered nurses, and prosthetists who had also been involved with physical therapist during ISL work.

Not only did these resonance checks test credibility and help to eliminate bias, but they tested two other important criteria for methodological rigor, namely that the results were both plausible and illuminating. It appears that my description of the phenomenon was supported by the persuasiveness of the argument and that therapists as well as other health care providers found the description to be credible, plausible, and illuminating. It appears to be an accurate and clear account of the experience of physical therapists not knowing what to do in an ISL work setting.

Reliability is another concern when conducting research and concerns the consistency of research findings so that replication might occur. Thomas and Pollio (2002) suggest that identical replication is not possible or even desirable in dialogic research, as no two interviews will ever be exactly the same. The test-retest approach to reliability in positivistic research is not the same in phenomenological research, as human description and meaning change over time as a result of changing experiences and new insights (Thomas & Pollio, 2002). Offering another understanding of reliability, Giorgi (1975) suggests that findings are reliable "if a reader, adopting the same viewpoint as articulated by the researcher, can also see what the researcher saw, whether or not he agrees with it" (p.93).

Thomas and Pollio (2002) further suggest that if studies on the same phenomenon or topic are replicated, certainly the word-for-word descriptions would not be expected to

be exact replicas, but the themes or constituents that emerge should be similar to those found in the original study. They further suggest that the aim of replication is to extend—not to repeat—the themes and relations obtained in the original study. In his Ph.D. dissertation, Ben Anderson-Nathe (2005) writes about social workers being stuck or not knowing what to do in particular circumstances. His description of the essence of the phenomenon for social workers may not hold for physical therapists. His pivotal study, however, opens the discussion on this topic. My findings contribute to the themes of not-knowing and professionalism in the context of physical therapy practice. In this way, this study's findings are reliable.

As a final word, Thomas and Pollio (2002) posit that one crucial test of any study is its relevance and value in bringing about new insights regarding the phenomenon studied. With these criteria in mind, Thomas and Pollio (2002) suggest that regarding their work, the readers or nurses and medical personnel would be the ones to directly apply the findings of the research to their practice if applicable to current patient cases. I posit that the physical therapists who have and who will continue to participate in ISL work will be the ones to determine the relevance and value of this study, as will the organizations hosting ISL physical therapy work activities.

Finally, Hostetler (2005) discusses the meaning of good research and what it entails. He suggests that all research questions come about because the researcher cares about something. How a researcher goes about answering his or her questions is dependent on that person's character (Walker, 2007). Furthermore, good research should "serve people's wellbeing" (Hostetler, 2005, p. 17). I feel that I met rigorous ethical standards while doing my research and that my overall goal was to illuminate the

experience of not-knowing in order to help physical therapists involved in ISL work. Additionally, involving the study participants and other practioners in ongoing evaluation of my description of not-knowing served as a means of ensuring that I created an ethically responsible and honest description of physical therapists' experiences of not-knowing during ISL work. This description will inform the professionals, programs, and patients involved in physical therapy ISL work.

Summary

This chapter reviewed the philosophical underpinnings of phenomenology and its use as a research methodology. The chapter also discussed the specific research journey I underwent in recruiting and screening participants as well as collecting and analyzing data. I also discussed the consideration of ethics, validity, and reliability in my phenomenological research. The following section provides the results of this study and a discussion of those results. Chapter Four presents the description of the general structure of the experience of physical therapists not-knowing during ISL work. A discussion of the results follows in Chapter Five.

Section II: Results

The true delight is in the finding out rather than in the knowing.
(Isaac Asimov)

My research process had been like taking a journey guided by the philosophy of phenomenology and my research methods. I met fascinating people, not the least of whom were the physical therapists serving as my participants. Further, I built rapport with my participants. I listened to and heard the stories my participants shared with me. I gained insights, learned things I could never have imagined on my own, and have come to see the phenomenon of not-knowing through multiple lenses and in a new light. It is my hope that others will connect with the stories shared by the participants so that they, too, will better understand the experiences of physical therapists' not-knowing during ISL work. In Chapter Four, I present the general structure of the phenomenon of not-knowing and its constituents. I present a discussion of the description and the specific constituents of not-knowing in Chapter Five.

Chapter Four

The General Structure or Essence of Not-Knowing

In this study, the phenomenological analysis revealed a description of the general structure for the experience of not knowing what to do for physical therapists during ISL work. The general structure of the experience was revealed to be one in which the therapists progressed through periods of surprise, shock, anger, guilt, self doubt, before being transformed by the experience of not knowing what to do. Eventually, the therapists were able to see how to move forward into action.

The common description of not knowing what to do resulted from the horizontal analysis of my data. It is no longer the description of an individual participant. Indeed, it is a common description of the essence of the experience of not knowing what to do for physical therapists in an ISL setting. It was created from the descriptions of all the participants and represents the particular attitudes and experiences of physical therapists who find themselves in this experience of not knowing what to do during ISL work. The general common structure or essence of not-knowing was a moment signified by four constituents: (a) a moment of surprise or shock when facing one's limitations; (b) a phase of strategizing or improvising; (c) a time of questioning one's vocation with issues of professional identity; and finally (d) a moment of illumination and clarity.

The stories that these physical therapists shared varied, yet the constituents expressed for moments of not-knowing were the same across all interviews. About the idea of a general form of an experience or phenomenon, Dahlberg, Drew, and Nyström (2001) suggest this:

> There is a general form or structure of the phenomenon, an essential meaning or essence to the phenomenon, which does not vary. In other words, this essence makes the object what the object is and thus we can speak of the object's, or thing's, essence or character. (p.193)

All participants spoke of the struggle they experienced and the reflective process they underwent during and after their experiences of not knowing what to do. Although phenomenology attempts to get at the lived experience in its prereflective state, it seems that some amount of reflection is a part of the process, given the way participants made sense of the lived experience of being a physical therapist engaged in ISL work during the second interview with me. Dahlberg, Drew, and Nyström (2001) state, "our residency in the lifeworld places us in the position of creative contributors to the meaning of the world" (p. 95). It was in the second interview that many participants were able to reflect more deeply upon the meanings their experiences of not knowing. In this way, the horizontal analysis of the data more clearly reflects individual details that were used in deriving the meaning of the common description or essence of the experience of not knowing what to do in the ISL setting for physical therapists.

Authors Dahlberg, Drew, and Nyström (2001) further state the following:

> Researchers must restrain their pre-understandings and encounter data in an unspecified and open manner as possible. When the researcher remains true to the data and suspends pre-understanding, the result is a description of the phenomenon as it appears, as it shows itself to the researcher, with nothing taken for granted about its "real" existence. A pure description of a phenomenon is, in

this sense, a description of its meaning, based on the experience of "the thing". (pp. 183–184)

Not-Knowing and Its Four Constituents

The following section describes each of the four constituents that comprise the essence or structure of not-knowing for any physical therapists engaged in ISL work.

Constituent One: Facing Limitations—Surprise or Shock: Oh, My God!

Moments of physical therapists' not-knowing occurred in many situations during ISL work. Not-knowing occurred in a therapist's role as leader dealing with surprises in the established plans of an ISL trip. Not-knowing during patient care was linked to being in a new environment, dealing with language barriers and translator challenges, time constraints, limited resources or information, limited space, unclear role delineations, and dealing with an unfamiliar health care system. Physical therapists in ISL work had their theories and findings questioned by physicians and others in authority. No matter the role played, ISL physical therapists were presented with situations that were initially shocking and puzzling. In fact, physical therapists were blindsided by this moment of not-knowing and it took their breath away. All they could say was, "Oh, my God!" These words were the response to a disorienting dilemma in which they initially didn't know what to do.

Physical therapists then had a moment of wondering how to give council, input, comfort, or support to the patients or others involved in the situation. They even had to stand up for themselves and their beliefs. They stepped back to organize themselves and examined the situation, taking it all in. The therapists were hit with the intensity of the experience, which led to an overwhelming feeling of paralysis. They felt like deer in

headlights for a short while. They sensed that something was not right and they began to breathe rapidly. They felt trapped by the situation and even desperate.

These physical therapists also experienced an embodied fight-or-flight response. It was a very intense reaction. They felt their hearts race, their stomachs churn, or their muscles tense. Physical therapists in the ISL setting felt the burden of the great weight that they must shoulder. Space felt like it was closing in and crowding them. Taking a step back either physically or mentally helped them recognize that the fight or flight response was their bodies call for attention to focus on the matter at hand. Further, the ISL physical therapists felt isolated and alone even when surrounded by a group of people. They realized others were looking to them for an answer and there were no superheroes coming to the rescue. It was just them and they were being called to action.

Constituent Two: Strategizing and Improvising: On the Fly by the Seat of My Pants!

Stepping out of the situation either physically or metaphorically allowed physical therapists to reflect on what was happening in the moment. Physical therapists realized they must think clearly and objectively in order to manage the situation, yet they could not let go of the raw emotion they felt from the situation. However, they focused on the situation in order to think logically. They strategized instead of engaging in a reactive manner. They recognized that emotions could come later. The ISL physical therapists were about to do battle with the situation. They asked themselves, “What exactly is going on?”

The flow of time was altered; it seemed to slow down as ISL physical therapists tried to take in the situation in order to make sense of the unfamiliar. It was as though

time was waiting for them to strategize and reengage in the situation at hand. The ISL physical therapists told themselves, “Oh, my gosh! I have no idea what to do. I’ve never seen this before. What to do? What to do?” This response reflected how challenging it was to have to be an expert in all areas of practice. And often there was no space to think or talk in private. Something about ISL therapists being from a foreign land seemed to expose their not knowing what to do in their given situations. A perceptive change in the rhythm and pattern of speech, as well as facial expressions or bodily postures, seemed to betray the ISL physical therapists. They could not mask their inability to know what to do. They carefully guarded their real emotions. They tried to put on happy faces and remain in the cognitive realm of problem solving. Yet it was difficult to completely divorce themselves from their feelings. They were not only doing battle with the situation, they are also doing battle with themselves in order to remain in control of the situation.

Relying on past experiences was one strategy ISL physical therapists used to stay in the moment as they began to problem solve; they thought back to previous patients or situations in which they had been successful. The basics that were successful previously did not help now. Previous training had not prepared the ISL therapists for everything. The unnerving and expanding uncertainty challenged their clinical judgment and self-identity as they tried to make sense of the situation.

Interpersonal communication cues were different in the foreign country when doing ISL work. Interaction protocols were also different. Speaking a different language was also a challenge. The responsibility attached to their role as professionals heightened the urgency to be knowledgeable, more so than when these physical therapists were

treating patients back home. Now, physical therapists were seen as the main authority or expert. Being seen as an expert was both helpful and challenging. Pressure mounted as the ISL physical therapists realized that foreign words held privilege. They were seen as experts with answers even when they had no answers. The role as a clinician or teacher provided some comfort, in that it allowed the therapists to ask questions to get an understanding of what was going on in a situation. Being able to ask questions was a privilege the ISL therapists held as foreigners. They chose their words carefully and used as much medical diplomacy as possible. They wanted to be respectful, and yet the ISL physical therapists were compelled to act to do the right things. They did not want to be seen as the arrogant, ugly American or arrogant Westerner.

The ISL therapists wanted to do no harm. Yet, ISL physical therapists realized their moment of inaction prepared them to shortly be in action. They realized they must engage. Before they could act, ISL physical therapists needed to figure out the rules of engagement. They began to mentally develop strategies and rehearse possible action plans in their head. The physical therapist professional core values and principles of ethical practice helped guide the plan. Recalling past experiences reminded therapists that, in the end, things eventually work out. Finding some comfort and hope in that thought, ISL physical therapists realized it is alright to proceed, even if they did not have all the pieces of the puzzle in place before they act. However, the ISL therapists understood they must remain professional. So they moved forward hoping to do no harm. Taking on a coaching role, ISL therapists asked, “What can we do now? What’s next?” They had lost their footing and proceeded by feeling their way though the situation. They proceeded on the fly and by the seat of their pants.

Constituent Three: Professional Identity and Self-Doubt: I Feel Like an Imposter!

Uncomfortable feelings of inadequacy, vulnerability, and hopelessness set in. Fear of being seen as an imposter led the physical therapists to question their professional identities. Self-doubt began to course through their minds. Disappointment in themselves as educated professionals filled their heads and clouded their vision. Accountability for their actions felt heavy, like a burden on their shoulders. "What will others think?" wondered the ISL physical therapists. The mood of the situation also seemed to cloud the moment, as all eyes were looking to the ISL therapists for answers. These ISL therapists felt their credibility slip away. They wondered if their qualifications measured up to the situation at hand.

A sense of anger wicked up from inside in the heat of the moment, a feeling that the physical therapists tried to conceal. The ISL physical therapists wondered if they had bitten off more than they could chew. They wondered if they had made promises they were unable to fulfill or if they were representing themselves as something they were not. They wondered if they had set themselves up as knowing more than they did. They felt like traitors and that they had misrepresented the truth.

Guilt of not being able to act efficiently in this new setting also tormented the therapists momentarily. The realization that a treatment could actually kill a patient or cause harm also set off danger bells inside their heads. Self-doubt became a barrier to moving forward. The therapists felt disregarded by others and themselves. They wondered what they were doing there in that situation. Soul searching allowed the therapists to wonder if they were worthy to be there and what they might offer the present situation. They then began to redirect their attention back to the situation at hand.

Constituent Four: Illumination And Clarity: When the Light Bulb Went On!

The therapists came to a realization about what to do, describing the experience as light bulbs going on in their brains. They could then see clearly what to do. They experienced a sense of shared, peaceful familiarity or comfort in that they no longer perceived the environment around them as hostile. After working through possibilities and deciding on a strategy, they then viewed the situation as an opportunity instead of a problem. They viewed this opportunity as holding a potentially rich learning moment. The ISL physical therapists stepped back into the situation and engaged in the reality of the moment. Time seemed to have caught up with them at this point as the therapists moved forward with their plans. At certain times therapists saw an obvious solution and at another times, there was no obvious solution to the problem at hand. Nevertheless, the physical therapists did the best they could, despite possible negative outcomes. One a plan was in place the therapists viewed the situation differently through transformed lenses. The therapists themselves were also transformed by the experience. The therapists then wondered what would happen to their patients after they would leave.

Summary

In this chapter, I presented the general structure of not-knowing, as well as its constituents. The general structure included moments of surprise, shock, anger, guilt, and self doubt woven together thus blinding the participants with how to proceed in the situations faced. Finally, the mood of the situation changed to one of seeing possibility, transforming how the therapists viewed the situation and themselves. The therapists were then free to act. Reflecting on their experiences, physical therapists became changed people because of their ISL work. Their eyes were opened to many things, such

as trauma and the overwhelming nature of human suffering. The ISL physical therapists spoke of seeing the importance of getting to the root of problems to find sustainable answers to those problems. As a result of their experiences, they could frame things better, in ways that helped others understand. They also had better understandings of moments of not-knowing and of themselves.

The following chapter provides a detailed discussion of each of the four constituents of the general structure of physical therapists' experiences of not-knowing during ISL work. The descriptions of the four constituents are supported with textual narratives from individual participants' stories.

Chapter Five

Discussion

In this chapter, I discuss in detail the constituents for the general experience of physical therapists' not-knowing in ISL work. This chapter will link my findings to what has been discussed in the literature regarding not-knowing and the philosophy of perception. I will return to the things themselves, that is, to the narratives as spoken by my participants, in order to enrich the discussion on the experience of not-knowing.

Constituent One: Facing Limitations—Surprise or Shock: Oh, My God!

Moments of not-knowing occur due to travel logistics, language barriers, unclear role delineation, or cultural differences, to name a few stimuli. All participants in this study described how a moment of not-knowing manifested itself in an international setting, whether they were treating patients as clinicians, teaching, consulting, acting in administrative roles, or conducting research. Often, resources were limited and the existential dimensions of time, space, and relationality were not the same as what the physical therapists were accustomed to when working in their home-country environments.

The participants described their experiences with strong, embodied terms. Participants shared their strong visceral response to situations which appeared to guide their understanding of the situation more than they realized. Andrew stated, "It is pretty gut-wrenching. In your gut you have that pitting, gnawing feeling and you think, 'Oh, I should have anticipated this.'" Jill, Renee Claire, and WL spoke of feeling "a lump well up" in their throat and chest. Bambi felt her temperature rise. Isabel, Jan, Sally, and

Wilma described their hearts “beating rapidly.” WL spoke of “feeling my heart pop.” By experiencing the situation through bodily reactions, the therapists reached greater understanding that something was not right in the situation they were facing even though they were not fluent in the language being spoken in the ISL country.

Participants also spoke of a lack of true understanding of the context into which they had been thrown as they engaged in ISL work. Jillian summed up the challenge of understanding the context of her work in an AIDS hospice:

> You come from a first world mentality and you go into a third world mentality. You have to sort of stop thinking first world and at the same time you need to maintain that barrier when working with a patient with AIDS. You need to glove.

That first world-third world mentality is a tough barrier to overcome. Others also spoke of coming to their sites with a first-world ways of thinking but having to function with a third-world mentality in terms of limited options for equipment and treatment. In this context the therapists found themselves faced with not-knowing or being stuck while others looked to them for answers.

The therapists in this study were facing unclear situations during their ISL work and had to project forward what they would do next. Thomas and Polio (2002) describe such moments this way:

> Each human life comes upon itself in the midst of some situation into which it has been “thrown” beyond the person's wishes. The task of life then becomes one of dealing with our “thrownness” and “projecting” it forward to new situations in which we may realize our genuine and unique possibilities. (pp. 16–17)

Each human life is then responsible for "its own being and becoming" (Thomas & Pollio, 2002, p. 17).

My participants were quite clear in describing how the first moment of not-knowing involved a shock or surprise which took their breath away. They were blindsided by a situation. This moment was, in fact, so surprising that every participant mentioned how he or she uttered one of the following exclamations: Oh, gosh! Oh, geez! Oh, my gosh! Oh, my God! In this way, the participants vocalized their limitations to act in their situation. The participants had lost their footing and were in unchartered territory. They sought help finding their way home to familiar footing.

Donna had been comfortable in her role as a clinician working in Asia. Then, when working on a particular case, she realized that the child she was examining after a clubfoot surgery had a terminal neurological diagnosis that the surgeon had entirely missed. She was in a hot, crowded gym, surrounded by families, other physical therapists, and students. Time unfolded slowly for Donna to get things moving forward. She did not feel that she had enough space or privacy to think, which only added to the difficulty of the situation. Donna stated:

> My options were really very limited. People were crowding around me and looking to me for an answer. All eyes were focused on me. There is no space for privacy and it is very hot as well. I wanted to go away somewhere to think but I couldn't. There was no place to go. That sick feeling in my stomach made me feel like I needed to climb away from everyone so that I could think through what I was going to do. I realized I was not going anywhere. My feet were planted

> firmly on the floor. I had to act but not let my thoughts betray the reality of what had just happened. A child had received an unnecessary surgery.

Donna continued her story:

> Oh, my gosh! This child cannot even sit up. He lacks the muscle tone to control his body against gravity. He appears to have a case of spinal dystrophy and it seems to have progressed rapidly. I suspect he will only decline toward death in the next few months. I wonder if the surgeon had even looked at this child before operating on his clubfoot. What to do? What to do?

Gary described how he experienced a moment of breathlessness when he observed the cesarean birth of a stillborn child. A woman had been brought into the rural hospital in Africa where Gary was working as a clinician and educator. This woman had given birth to the first twin in her home village when she began to develop some difficulty delivering the second child. A local healer had been brought in to assist with the second birth, but with no success. Finally, the woman was brought to the hospital on a donkey. Gary and his students then observed the cesarean section of a dead fetus.

A moment of childbirth should be joyous, and yet this woman faced birth pangs and the reality that she would mourn a child she would never know while raising the surviving twin. During the cesarean section procedure, the medical workers simply reached into the woman's abdomen, removed the dead fetus, put it in a plastic bucket, and carried it out of the room. The woman was suffering and Gary wondered what to do. Should he give council, input, comfort, or support to the woman? He also wondered about his students. He described this moment this way:

> You come face to face with a situation. It is like a disorienting dilemma and you wonder what to do. It hits you like a hard left. You sense a struggle but you can't run from it. At first the situation envelops you fearwise. You don't know what to do because of fear. You are processing through the challenge and you think, oh, my gosh! I've done this, but oh, gosh! I was thinking about what that woman needed more so than what my students needed. I proceeded to move up front by the woman and started to stroke her head and hold her arm. I didn't know the rules of how men and women interact here. And then just as I did that, one of my female students came up and held her hand. I just stepped out of the way and she did it. Later, when the lady left after her procedure, she smiled and reached out to shake all of our hands. That evening when my students and I walked home in silence, all we could think about was that "oh-my-gosh" moment we had just witnessed and experienced.

After developing a new clinic in collaboration with a church in rural Mexico, Ella realized she had taken on much more than she had expected. On one occasion, she faced a long line of families with children of all ages waiting to be seen. She was the only physical therapist working that day and there was not much equipment in the small room that served as the makeshift clinic. Ella described having to come face to face with limited resources and the extreme needs of the children:

> I became overwhelmed with the great needs and the great numbers of children. I thought, oh, my gosh! I didn't even know this problem existed. You have to figure out a lot of stuff. Standardized ways of evaluating children in the United States won't work here. There are no medical records so you don't really know

> what has been done. You don't know what to do. You are stuck. It is a paralyzing moment. You feel all alone and are faced with self-doubt. I wonder, what am I gonna do? Then the emotions hit you later when you realize the enormity of the situation but now you have to act.

In summary, my participants had been thrown into new situations involving ISL work that offered no guarantees that they would successfully meet either personal expectations or the expectations of others. They were left with a sense of surprise and shock where even words failed them. Several sub-constituents compose this initial constituent of surprise and shock and include a paralyzing moment described as a deer in headlights, experiencing the gaze of others, fight or flight as a call to focus, wondering what to do, and a desire to be understood.

A Deer in Headlights: Paralysis by Analysis

Most participants described themselves in this moment of not-knowing initially as being like a deer in headlights. In her description of events, Joan remembered thinking, "Oh, my gosh! I have no idea what to do. I have never seen this before. What to do? What to do? I feel like a deer in headlights." Others described a similar response. Despite her many years as a clinician and a researcher, Vanessa faced a medical tribunal that was questioned her ability and knowledge regarding screening and working with infants. Her research was also being discounted and dismissed since she was a woman. She described the way that her deer-in-headlights moment in front of the tribunal made her feel small and unable to act. She stated, "Gosh, I know nothing. I am unable to move or think."

As a consultant in the Caribbean, Katrina encountered many children with severe deformities in an orphanage near the end of her service-learning trip. In our interview, she further explained that her limited time often left her helpless, with a deer-in-headlights feeling:

> You experience an embodied fight or flight response. It is a very intense reaction. I am overwhelmed with an intense feeling of needing to take action but I don't yet know what to do. I am churning. I think, oh, my gosh! I can't believe this is their reality. What can we do? I am in turmoil and can't sleep at night because I am processing everything.

For all participants, the description of feeling like a deer in headlights captured their feeling of paralysis by analysis, where the physical therapists took in information and attempted to make sense of the unfamiliar situation they encountered. When probing further about what the participants meant by "deer in headlights," the participants clarified that it is a moment of helplessness where panic sets in. They cannot think or move. They want to run from the situation, but feel trapped by the moment at hand. They simply do not know what to do. Maddie described feeling like a deer in head lights as a moment of last resort when "you grab at anything in your brain, but there is nothing concrete you can put your hands on to help you know what to do." Bambi described how she felt like she was back pedaling trying to let her thoughts catch up with the shock of the moment she had just faced during her deer-in-headlights moment. These participants came face to face with their limitations as professionals and as human beings. Upon realizing their limitations professionally and as humans, the participants resorted to

invoking help from a greater being as they exclaimed, “Oh, gosh!” “Oh, geez!” “Oh, my gosh!” “Oh, my God!”

According to an online dictionary (Cambridge), people use phrases like “Oh, my God!” to describe or emphasize how surprised, angry, or shocked they are to encounter the unfamiliar or unknown. In my participants’ cases, they were unable to put into words what they were feeling or experiencing. Language failed them. The participants were speechless. On the use of language, Maurice Merleau-Ponty (1973) writes, “Language is the child in us who speaks of the world in order to know who he is. Through language I discover myself and others . . . . and thus we make our world” (pp. xxxiv-xxxv).

The comfortable world of physical therapy was altered for my participants in their uncomfortable moment of not-knowing. Their relationship between themselves and their world then became unfamiliar. As a being in a there, that is, as *Dasein*, there is no longer the “reciprocal exchange with the instruments which it [Dasein] uses” (Merleau-Ponty, 1973, p. xii). The participants’ professional tools failed to be useful. Their tool of language also failed them when, in their discomfort, my participants cried out for help. In so doing, they experienced the opportunity to discover something about themselves that they had never known. Merleau-Ponty (1973) further states, “Our language recovers, in the heart of things, the word which made the thing” (p. 4). In *The Prose of the World* (1973), translator John O’Neill suggests the following:

> Language, like culture, is often regarded as a tool or an instrument of thought. But then language is a tool which accomplishes far more and yet is far less logical than we may like it to be . . . . As a tool, language seems to use us as much as we use it. In this, it is more like the rest of our culture, which we cannot use without

> inhabiting it . . . . It is through our body that we can speak to the world, because the world in turn speaks to us through the body. (p. xxxiii)

My participants found themselves in settings that should have been familiar to them because of their professional training. Yet they encountered situations that made them feel inadequate and without answers, at least for a short time. Macann (1993) states the world is social, cultural, and ever changing. Accounting for the experiences of the participants, he suggests the following:

> The world not only welcomes and accepts, it also revisits and rejects; it is not only that in which I find myself but also that which surpasses any experience I can ever have of it; it is not only that in which I find myself at home, it is that in which I am alienated from myself, in which I find myself estranged—and it is the source of many schizophrenic disturbances. (p. 190)

In summary, after feeling the surprise and shock of the situation, the participants are at a loss for words. They are unable to move forward in action as they attempt to make sense of their situation.

The Gaze

The situation of not-knowing presents itself as a disorienting dilemma (Mezirow, 2000) or a grand puzzle. Complicating the process of moving forward into action is the fact that all eyes are on the physical therapist professional. Feeling the gaze of others momentarily adds to the pressure compounding the inability to move forward into action. Donna, realizing in her situation that the surgeon had operated on the child's clubfoot without doing a thorough holistic exam, was shocked. Through her physical therapy exam, Donna learned that the child she was examining had a very serious underlying

neurological diagnosis that had been overlooked by physicians, thus making the surgery to correct the clubfoot deformity a moot point. The boy would never walk again, even if a surgery had been successful, due to his underlying neurological issues.

Donna realized that this straightforward case had become much more complicated in the middle of rounds with her students and other therapists from her host country in Asia. Despite the language barrier, Donna was unable to hide her understanding of the reality of this situation. A physical change in her being indicated to others that something out of the ordinary had just happened. Donna reflected on the situation, recalling her assessment at the time:

> Everyone is around you just looking at you in that situation and realizing something's going on and wondering what is wrong. There is something about your very being whether it is the cadence of your speech pattern, your facial expressions, or your body language that seems to give your inner turmoil away. You are betrayed by an expanding uncertainty which challenges your clinical judgment and self identity. There is no way of communicating what you are thinking without doing "no harm." It is like I lost my footing and now I must proceed by feeling my way through the situation. I have to figure out how to talk to the surgeon and how we might all save face.

Bambi experienced her moment of not-knowing when she walked into a classroom to teach health-care professionals in a country that had just been through a civil war. She was brought in to teach the country's new team of desperately needed community health workers about rehabilitation. Bambi had expected to have only 15 students in her course on rehabilitation. Instead, she found 27 students crowded into a

very tight and small classroom without enough desks or chairs for everyone. There were not enough books or handouts for all the new students. All eyes were on Bambi. She felt the intensity of multiple gazes upon her being. Recalling this moment, Bambi said the following:

> It is a paralyzing moment. I felt like a deer in headlights as I was faced with analyzing the situation. You feel alone. You are faced with self doubt and you wonder what am I gonna do? For another brief moment I feel angry and resentful, not knowing who to be angry with. I feel a lot of doubt. I wonder if I had tricked myself into thinking I was more capable than I actually am. I question how I am representing myself. I feel all eyes on me as I begin to connect the dots of reality with which I am facing. I feel little trickles of fear starting to wick towards my chest. My temperature is rising. At first I am kind of back pedaling but then I realize I must engage. I may look like a composed teacher on the outside but I am doing battle inside my head. I certainly don't want to let people down. I know I need to do something and get the job done. Suddenly I realize I can shift gears and alter my course. It is like moving through a maze. You just do the best you can.

As the physical therapists were presented with new information, they struggled to find meaning and make sense of the situation and the context in which they were situated. Andrew and others questioned their qualifications as they were brought into focus by the gaze of others. Gary tried to pull away into a bubble inside his head and decide what to do. Donna imagined herself climbing away from the situation, yet she clearly felt her feet firmly planted on the ground. Other participants spoke of stepping back either

physically or metaphorically in order to sort through things. When past experience did not inform the current situation, most physical therapists spoke of the embodied fight-or-flight response that momentarily captured their attention and body. Although this fight-or-flight response temporarily made the therapists incapable of moving forward, it served to provide a greater awareness of themselves and a deeper perception of the situation. This moment of deeper perception allowed the therapists to create time for discernment and problem solving. Perhaps the fight-or-flight sensations helped the participants forget the gaze of others and refocus on developing a plan for action.

From a position of inaction, therapists described how they were able to develop a plan to be in action. In our interview, Gary described this moment of creating time for himself to think, despite crowded conditions with all eyes on him. He said this:

> There is a time warp thing, which allows me to pull away into a bubble and decide what to do. You become a head in a bubble just thinking and watching. You question your values momentarily. You step away from the emotion of it. You need a moment to pause. You step back and wonder what to do. You really look at the situation and take it all in. I don't know how that happens. I think it just happens. It's like I'm in a little bubble watching this happen and then kind of deciding what I should do.

To my question, "When you're in that bubble, what does it feel like to be you in that bubble?" Gary said this:

> I'm just kind of observing, and just processing what needs to happen next. Over what I should do next, or how can I help here? What is the next move, you know? Um, I don't really have a sense of me other than if I were to think about it

sometimes I think I am just a head in this bubble because I am thinking and watching. And I don't know what else is going on here. It's just this observation thing that I'm doing. Yeah. And then I come to some conclusion. And then I step back in. I kind of I don't know. It's probably kind of a physical initiative. It's either stepping toward or stepping back, but it's a physical movement of some kind where I'll engage again then somehow.

All participants spoke of the uncomfortable feeling of having all eyes gaze upon them in those moments of not-knowing. The physical sensations described by all participants in this moment pointed to a hyperawareness or a heightened sense of self, body, other persons, and the social situation in which the participants found themselves trying to perform their professional roles. Thomas and Pollio (2002) suggest that occasionally a person does not experience this hyperawareness until he or she makes a misstep. In my study, this hyperawareness did not indicate the participants had done anything wrong professionally; it suggested, however, these physical therapists were outside of their comfort zones. Indeed, they spoke of taking missteps or being in unchartered territory, losing their footing, trying to find their way home.

In all cases, the gaze of others heightened the intensity of the situation and the uncomfortable aspects of the experience of not-knowing. Merleau-Ponty (1945/1962) states the following about the power of the gaze:

In fact, the other's gaze transforms me into an object, and mine him, only if both of us withdraw into the core of our thinking nature, if we both take ourselves into an inhuman gaze, if each of us feels his actions to be not taken up and understood . . . . This is what happens, for instance, when I fall under the gaze of a stranger.

> But even then, the objectification of each by the other's gaze is felt as unbearable only because it takes the place of possible communication. (p. 420)

Participants were very clear about the uncomfortable feeling that resulted from their perceived gaze of others. One might say that this gaze is what reduces people (beings), or the *sein* of *Dasein,* into a *da* or there. My participants became removed from their existence as figures or as beings-in-the-world. They were reduced into the ground of the new social order in which they were situated. They did not fully understand how to engage. They become a there or ground for others, allowing others to be figures and to exist. Indeed, Merleau-Ponty says, "It may be said that the body is 'the hidden form of being ourself' or on the other hand, that personal existence is the taking up and manifestation of a being in a given situation" (Merleau-Ponty, 1945/1963, p. 192).

Furthermore, Merleau-Ponty (1945/1962) suggests that the gaze of another has power, such that it becomes an "alien gaze which runs over his body stealing it" (p. 193). In such an instance, the gaze of the other reduces the status of the person being gazed upon to that of an object instead of a being. This situation causes the gazed upon to experience shame, according to Merleau-Ponty (1945/1962):

> In so far as I have a body, I may be reduced to the status of an object beneath the gaze of another person, and no longer count as a person for him. . . . Saying that I have a body is thus a way of saying that I can be seen as an object and that I try to be seen as a subject, that another can be my master or my slave, so the shame and shamelessness express the dialectic of the plurality of consciousness, and have metaphysical significance. (p. 193)

Our place in the social order is affected when we do not understand it or our role in it or why others may be gazing upon us. Thomas and Pollio (2002) suggest that the social order is defined by more or less explicit rules instituted to regulate human behavior. Furthermore, they state, "Sometimes these rules and norms are collected together into a single entity called a social institution. The total order of any society consists of many different social institutions, each with its own rules of conduct, accreditation, and concern" (p. 105). In their study on social aspects of relating to others, Thomas and Pollio (2002) asked participants about their experience of losing a connection to other people in their everyday experiences. As a result, Thomas and Pollio (2002) found a relational awareness in the patterns of our day-to-day dealings with people. There are moments of closeness and synchrony as well as those of distance and asynchrony. It is in those moments of asynchrony that we judge and categorize others "as similar to and different from ourselves, each other, and/or social norms" (p. 107). It is here where a figure-ground reversal occurs which makes "figural the normally invisible ground of social structure" (Thomas & Pollio, p. 105). This inability to move forward when caught up in the gaze of others heightens our sense of surprise or shock and temporarily stalls us in our ability to move forward toward action.

The new environment of working in an international setting changed the rules of engagement for clinical practice and even personal interaction. The participants in this study needed extra time to make sense of what to do when not-knowing. The rules of engagement varied from the expected norm known to my participants in their homeland. Furthermore, time became distorted as the physical therapists worked through their moments of not-knowing what to do. In their estimation, time slowed down as the

physical therapists faced unexpected situations that did not resonate with their previous experiences. Later, they experienced time speeding up as they attempted to find solutions to their problems.

Isabel shared how time became altered for her when she did not know what to do as the cab she was riding in with her students to a work site was pulled over by the police. Her driver stopped for a moment and then sped away. Isabel did not have anyone else to pattern her behavior after, and with her limited command of Spanish, she was left to wonder about the situation and the safety of her students. She describes how time becomes altered in a moment of not-knowing:

> It didn't take a lot of time. It probably took about three minutes but it seemed more like 10 minutes. Yes. It probably seemed like 10 minutes, um . . . I think at the same time it seemed really fast and then at the other time it seemed really slow. It was an interesting experience. My heart rate increased. I am trying to think. The main thing I am thinking about is my student's safety, primarily. You know, what's this guy gotten pulled over for? You know, is he going to hurt us? My students are looking at me trying to make sense of me and the situation and yet, I don't know any more than they do.

Other participants described time passing slowly or feeling like an eternity when living through the experience of not-knowing what to do. Jillian spoke of how time moved slowly as she attempted to make sense of the situation in which a woman she had just cared for collapsed onto the dirty floor of a hospital in the Caribbean. Others spoke of time waiting for them to think before they could determine how to engage in the

situation. Physio describes how time eventually became irrelevant in her situation of seeking medical help for her injured and bleeding student. She stated:

> There is no concept of time. Basically, time stops literally from the moment I receive the phone call and I find myself in a cab on the way to the hospital. The next thing I know is that I am in the hospital and am being asked to pay for the x-ray and suture points. I have no concept of time because I am just functioning on automatic pilot in the moment. I focus on what needs to be done next and I do it, not at all watching the time pass. Time in fact, is irrelevant at that point yet others are looking at my every move.

These moments of indecisiveness or feeling helpless—like a deer in headlights—were more than single moments of paralysis by analysis. In fact, these moments may have been part of a process of critical thinking, of using inductive reasoning to make sense of all the possibilities a patient situation may present (Elstein, Shulman, & Sprafka, 1978). When considered in isolation, as only one step, the feeling of being like a deer in headlights and of having to invoke a higher power can certainly make one feel that one is a failure as a professional. However, when considered as a process of inductive reasoning for clinical decision-making, the moment becomes a means to an end rather than an end in itself. In reality, one is not a failure, but is experiencing and engaging in a process of gaining clarity. When experiencing the moment of not-knowing, however, it is difficult to see beyond the present horizon or moment of perceiving oneself as a failure.

In the famous medieval play *Everyman*, Death states, "For, wit thou well, the tide abideth no man" (Dent, 1956/1993, p. 203) which is often translated as "Time waits for no one," (Reference.com). These statements suggest that time is a constant which

marches forward independently of anything else. Yet, Einstein discussed the relativity of time in his *Special and General Theories of Relativity* in the 1900s. Einstein (1920/2006) suggests that time "will go more quickly or less quickly, according to the position in which the clock is situated (at rest)" (p. 74). He further stated, "Wait a moment. Time is not so constant as Newton said; it meanders, and speeds up and slows down around stars" (Reference.com). Furthermore, Macann maintains that "time is the measure of our being in a social and cultural world" (1993, p.190).

Perhaps the perception of another's gaze alters how one views and lives time. In my participants' experiences of not-knowing, reality, then, nudged them, as they felt time slow down and speed up, toward the moment during which they had to reengage. Before engaging in the present however, the participants had to face their limitations, engage in battle with their identities as professional physical therapists, strategize, and improvise before gaining clarity. In the next section I discuss the details of the participants call to focus on the situation through facing their embodied fight or flight sensations.

Fight or Flight—A Call to Focus!

Typically, feelings of fight or flight indicate that something is not right. Sometimes this feeling was blatant, and other times it was not so obvious. Adrenalin from the fight or flight response provided therapists with an unnamed power and an ability to act, despite being unsure of what to do. Participants were left to make sense of the situation by their intuition because they were foreigners in the culture in which they were situated. Yet as participants navigated the course to finding a solution to their problem, the familiar fight or flight sensations often reoccurred, warning the physical therapists that they had indeed strayed from the right path and should redirect themselves.

My participants even found comfort in those uncomfortable but temporary feelings of uncertainty. Sensations from the fight-or-flight situation actually transformed the physical therapists, propelling them forward with a physical sense of purpose as they strategized what to do next.

Participant Physio encountered and embraced this uncomfortable physical fight-or-flight feeling and allowed it to guide her as a system of checks and balances in her role as coordinator and administrator of an international clinical program. One day, she and her physical therapy students divided into teams for a scavenger hunt in the city in order to learn their way around their new environment. Physio was out with one group of students and received a phone call during which she learned that one of her students in another group had injured herself and was standing on a corner, bleeding. Fortunately for Physio, another student in her group had lived in the country previously and had an excellent command of the language. In an interview, Physio shared her experience:

> I received a phone call that one of my students is injured. I felt like a deer in headlights but only for a moment. I think, oh, my God! Why did I leave them alone? Panic sets in. All I hear on the phone is that a student is hurt. She is bleeding and can't keep walking. I know nothing more. My mind starts to sort through the possible scenarios. The student's toes could be hanging off her foot for all I know. Panic is the word I use to describe that sick, heavy feeling of not-knowing in that moment. The adrenalin kicks into my body's system. I recognize this sensation as the fight-or-flight response. I want to be there with my students. I want to be Superman, but I am faced with my human limitations.

There is a conflicting sense of urgency and isolation that Physio had to deal with in her moment of not-knowing. The message that something was not right had been delivered to Physio. Her limitation was in how to physically reach her student in a timely manner and to seek the care needed by this student.

Maddie and George were a married couple working in South Africa after graduating from a physical therapy program in the Netherlands. They had come to South Africa to serve as physical therapists. Maddie was working in an official capacity as a consultant and physical therapist instructor, while George was a volunteer accompanying his wife. Maddie worked in an orphanage while George worked in an HIV clinic he established at the center. Both had opportunities to work in the small hospital at the center's compound. Late one night, when they were out driving around the city, Maddie and George were summoned back to the hospital at the center's compound through an urgent phone call. There was a boy with severe pneumonia who was struggling to breathe. After assessing the boy, Maddie and George realized that the boy was unable to get much of a breath in or out of his lungs. They only heard a sickening gurgle. George shared the details of their story:

> Listening to this boy struggle to breathe took our breath away. All we could think was what do we do? We noticed a suction machine in the corner of the room. It is an archaic looking beast. We don't even know if it works. Time slows down a moment for me to recall that I have seen suction being done in a hospital before when we were back home in the Netherlands with all the hygienic parts and the bag, but I have never done it myself. Most importantly I am being pushed by the reality of the situation. I realize that if I don't do anything *right* now, the child

will not live through the night. Panic sets in for a moment as I realize the gravity of the situation. It is that fight-or-flight sensation taking over my own body and calling me to focus on what needs to be done. Nothing is hygienic. After a brief discussion, Maddie and I find ourselves looking at each other, the machine, and the child. I think indeed we did both kind of fight over who is going to have to be the one to do it.

Maddie added this comment:

> Yeah, but we both took turns. We had to get over that fear of you know hey, we could kill this child or he could die otherwise. When you don't know what to do it is like you are a deer in headlights for a brief moment. Time seems to slow down as I realize something is not right. This is not what I am expecting to have to do tonight. Time seems to pause a moment for me to gather my wits. At times I feel my fight or flight system turn on but I realize it is my body's mechanism to help me in my decision making as I grab at possible plans of action in my head. That feeling helps me focus on the immediate action that I must decide to take. I think we both really celebrated that it could work but we just didn't know for sure.

George continued:

> In going back to the moment, you know, I am trying to put the machine together so it will work. We sterilized it to the best of our abilities even though sterilization of the machine is really quite secondary right now. A life hangs in the balance. We realize that if we two do not act, the child will die. We get over our real fear that we may kill this child. We act with each of us trying our hand at

> the suctioning process. Suddenly, there is a great deal of phlegm that comes out of the child's lungs. It is working! We actually got a lot of phlegm out using that suction machine. The boy's breathing appears to change. We see relief in the child on his face and then his accessory breathing muscles appear to relax. When we listen to the young boy's lungs, they are clear at least for the time being. We have success! We two breathe a sigh of relief and celebrate that at the moment we have been successful and that suctioning has worked. The child is able to sleep through the night. And indeed it does give you a great sense of pride when you have this freedom and you have no supervision and you have to make that choice to do something and it pays off. You know, it is a good feeling.

Maddie added, "Yes. And he lived for almost a week."

In *Phenomenology of Perception*, Merleau-Ponty advocates using phenomenological description to restore the world of perception (Moran, 2000). Moran (2000) also suggests that Merleau-Ponty's writings link "the origins of our experience of community, our experience of the other, and the nature of time" (Moran, 2000, p. 417). These themes are clearly relevant in the experiences of my participants as they were challenged to make sense of their experiences in the new communities in which they had to do ISL work. They are also relevant to their perceptions of time and to the way the participant's had to relate to others. For example, because of the newness of the community, the people, and the unwritten rules of culture, my participants were thrown into situations in which they perceived great needs but did not have enough freedom to meet those needs while under the gaze of others. Their sense of urgency and need for freedom to act created an interesting tension within the constraints of my participants'

situations. They lacked access to the degree of freedom they normally required in order to act as professionals. Illuminating the nature of this tension, Moran (2000) states, “Humans live between necessity and freedom. Our peculiar life experience is formed out of physical contingency and the manner in which we inhabit the contingent realm and make it our own” (p. 416).

My participants were faced with demanding situations and had to act. Yet the uncertainty of the environments into which the participants had been thrown made it difficult for them to project themselves forward. These participants had embraced their identities as physical therapists and had understood how to live the profession’s core values, acting according to the code of ethics that defines the scope of physical therapy practice. The code of ethics had helpfully guided behavior at home, but the therapists experienced some uncertainty about the code’s appropriateness in their new ISL work settings; the participants realized they were not the center of the universe in the foreign lands in which they found themselves. Isabel spoke of “carrying a professional duty regarding the responsibility for my students and my patients.” Katrina stated, “You must do no harm.” Andrew kept the core values and code of ethics in mind as he figured out his next steps. The physical therapists in an ISL work setting may even be asked to do things that lie near the boundary of their scope of practice where there is less familiarity in how to successfully accomplish what needs to be done. Merleau-Ponty (1945/1962) describes the challenge of reconciling such situations:

> Our body and our perception always summon us to take as the centre of the world that environment with which they present us. But this environment is not necessarily that of our own life . . . . Besides the physical and geometrical

> distance which stands between myself and all things, a 'lived' distance binds me to things which count and exist for me, and links them to each other. This distance measures the 'scope' of my life at every moment. Sometimes between myself and the event there is a certain amount of play (*Spielraum*), which ensures that my freedom is preserved while the events do not cease to concern me. Sometimes, on the other hand, the lived distance is both too small and too great: the majority of the events cease to count for me, while the nearest ones obsess me. They enshroud me like night and rob me of my individuality and freedom. I can literally no longer breathe; I am possessed. (p.333)

In summary, the gaze may seek to possess us while fight or flight attempts to free us from our inability to move forward in action. The physical therapists must decide what to do without having a complete understanding of the situation.

All Alone . . . What Do I Do?

For the participants in this study, the moments of not-knowing what to do involved facing one's limitations as a professional. The discomfort of not-knowing was compounded by a loss of control as the physical therapists felt helpless or vulnerable when facing their professional responsibilities. All participants described their loss of control as a sense of helpless and physical vulnerability. The sympathetic fight-or-flight arousal catapulted the physical therapists into a heightened bodily awareness as they negotiated a solution in their minds. Many participants recognized that, despite the uncomfortable feeling of the familiar fight-or-flight sensations, these feelings were the body's way of calling them to focus on the problems they faced. They described feeling their hearts beating fast, their chest pounding, their heads aching, their stomachs knotting

up, and moments of profuse sweating. They struggled to look in control despite being completely panicked on the inside.

Many participants described feeling isolated even in a crowded clinic. They experienced a breakdown in their ability to connect and to communicate with others in immediate situations. Just as they struggled to find adequate words to express themselves during their initial stages of not-knowing, in latter stages they struggled with their very being-in-the-world. The participants as perceiving subjects experienced their bodies as their own against a ground. It was a *Dasein* encounter in which they were conscious of themselves and their surroundings to a heightened degree. An important shift in reality occurred as the participants found connection with the patients or others they were serving in their capacity as professionals. The participants felt compelled to make conscious choices to engage, despite the limitations they perceived. In doing so, they connected to other beings, as Merleau-Ponty (1945/1962) describes when he states, "To be consciousness or rather *to be an experience* is to hold inner communication with the world, the body and other people, to be with them instead of being beside them" (p. 111).

Choosing to engage was not always easy for my participants. They were forced to determine how to engage in their given situations while being possessed by the situation and also from being situated in a place of not-knowing. Finding themselves possessed by the moment, the physical therapists were not free to ignore the situation; they were, however, free to choose how they would engage in the situation. The professional duty of my participants summoned them forward into engagement. There is not much play (*Spielraum*) in professional situations, as the professional code of ethics calls physical therapists to engage while also abiding by the moral principle of doing no

harm. Despite feeling a trapped and feeling that they lacked significant freedom, the participants moved forward, exercising the freedom to choose how to engage, despite limited options. Some participants battled with the situation and their self identities; others asked questions, drawing on their identities as teachers; some braced themselves for difficult conversations with others; and some simply moved into action. Regardless of what they did, they all made conscious decisions to move to action.

Upon arriving at her service site, Jan learned that the orphanage where her team was supposed to work for the following 10 days in Central America had new policies preventing her group from accomplishing their goals of working with the children with disabilities. Jan spoke of the contradictory feeling she experienced as she entered the cultural world of her ISL work site. Not sure if the situation was the result of a misunderstanding or truly was a policy change, Jan did not want to burn bridges with this organization, yet her group had dedicated much time and money to come to this community. The current therapist in charge of the children was an inexperienced volunteer from Europe who refused to allow Jan and her students the access they needed to work with the children. Jan recounted the situation:

> I had to put on a happy face when I would rather be angry. My happy face becomes my suit of armor as I make the best of the situation hiding my true feelings and emotions. I have to be a peacemaker and a problem solver at the same time and yet I am also engaged in a battle of gaining clarity of this situation.

Despite the pressures felt by the experienced physical therapists, being faced with a new culture and language augmented their feelings of anxiety or helplessness, adding to the pressure of having to know what to do yet not immediately knowing the right course

of action. The participants commented that they felt they were being seen as outsiders with special knowledge who had been brought into foreign settings. They were supposed to hold the key, to have both knowledge and answers. Because of this special status, they felt added pressure to have to act, and act correctly in relation to others.

A Desire to Be Understood by Others

All physical therapists spoke of the challenges of a language barrier, wanting to be understood, and not wanting to offend anyone. Physio shared how working in the international setting is a challenge. She stated:

> It goes beyond the words that are said. It goes beyond the body language that we tend to rely on. You know, we can all be sitting around the same table but you never know what you're going to get in the end.

Jack spoke of how the cues he faced in Africa were not what he was accustomed to dealing with back home:

> It was really strange to be trying to communicate and the cues you are receiving are so different from what you are used to seeing. You don't really know if you are right or wrong. You certainly don't want to offend anyone. It is a real challenge. You just do the best you can.

Sally expressed similar sentiments when she shared about the difficulty of communication in a country where Spanish was typically spoken. She said this:

> Language is a challenge if there are no physical cues like when you are trying to speak on the phone. Phone calls are almost impossible to make for consult purposes. If you ask someone to help you make a call, they don't often say what you have asked them to say. Understanding the response is just as difficult and

> adds to my stuck feeling of not-knowing. Working in another language is like being in a cloud of fog that you walk around in. Sometimes the fog clears quite a bit and I am less confused. Other times I am clueless. You are often left in limbo.

Metacommunication skills necessary in the ISL environment may differ from those with which a physical therapist is accustomed to using in his or her everyday practice in the United States. Briggs (1986) challenges researchers engaging in cross-cultural work to consider the nuances of how these metacommunication skills will be perceived, understood, or even interpreted when conducting interviews. Interviewing and communicating with patients, families, and other health-care providers is a large part of the work that physical therapists do in their health-care practices. Physical therapists engaging in ISL work may not even be aware of the hidden meanings behind the cues patients and others give, complicating the meaning-making processes during personal encounters in an ISL experience. Indeed, taken-for-granted values or frames of references that are historically and socially produced may cloud meaning and challenge the physical therapist to develop new rules of engagement (Edwards & Jones, 2007).

Merleau-Ponty (1946/1962) describes how civilization is the community in which we play. Civilization presents to us the instruments with which we engage others in our community. If the instruments such as language and our protocols for interaction are not familiar to us, as when we find ourselves in a foreign land during ISL work, we discover different manners of being that are made evident through our perceptions of our own broken instruments, which do not serve us. In such cases, we discover something more

about ourselves and others in the landscape through or ground on which we roam. Merleau-Ponty (1946/1962) states this:

> The cultural world is then ambiguous, but it is already present. I have before me a society to be known. An Objective Spirit dwells in the remains and the scenery. How is this possible? In the cultural object, I feel the presence of others beneath a veil of anonymity. *Someone* uses the pipe for smoking, the spoon for eating, the bell for summoning, and it is through the human act and another person that the perception of a cultural world could be verified. (p. 405)

For the physical therapists in this study, language, relationality, temporality, and spatiality were not the only challenges faced. Differences in metacommunication also clouded the events faced by the therapists in this study.

You Must Do Something

After learning that her student had been injured while on a scavenger hunt, Physio was forced to figure out what to do next. She relied on the tools at hand. The student had cut her toes and was bleeding quite a bit. Physio shared the rest of the story:

> You rely on your professional knowledge and training for dealing with the situation. Looking around, I notice that the public hospital we have a relationship with is just kitty corner from where we are in the cab with my student. Taking my student to this hospital where I have a relationship seems like the best option. This hospital is where our program has a relationship and clinical affiliation. I don’t know them personally, but they know of our group and our program. I stop the cab and move toward the hospital entrance. I want my student to be okay.

My student is rushed into the hospital straight back to the exam room, completely skipping triage, ahead of people who are bleeding and in worse shape than she is. I know in my head it is not fair for her to be seen before the others, based on her skin color, yet all I want for her is to be alright. I see her as my child and at this point I just want my child to be okay. You cannot worry about what is fair or not. It is after the fact that I realize that others who were much worse off are still waiting to be seen yet my student is given preferential treatment because she is the white American girl.

Suddenly, I am hit with a new surprise and feel like a deer in headlights for another short moment when I am told my student needs an x-ray. Being told that is not the strange part. What is strange and unfamiliar for me is to be told that I must go to the cashier's office to pay for the x-ray before it is done. I respond in the moment with action and ask where the cashier's office is located and simply say, "Let's go!" There is no debate. Once I know the rules of engagement, I can now act in the moment.

Another surprise occurs when I am told the student needs sutures and that I must go to the pharmacy to purchase a suture kit of needles and thread. Again, I am facing the unfamiliar and that deer in headlights sensation returns. It actually allows me to step momentarily out of the situation to strategize. I hear myself say, "Excuse me, what?" Then I realize the wisdom and importance of this step in the process. At least then I will know that the suture kit is aseptic.

Then the directors from our program came. And they said, "No, no, no she should not be here. We are taking her to the private hospital." And they took

> her to the other hospital. And that is when we realized that the care she was receiving at the public hospital was just as good. But right away they took the white girl away from the public hospital, and brought her to the private hospital, which was basically run like an American clinic. I then moved through the panic and immediate action phases into a phase of anger as I realize that there will be no superheroes coming to the rescue. Even my on-site directors know nothing more than me.

Physio described her reality in which she did the best she could in an ambiguous situation. Moran (2000) clarifies this point, stating, “Every human situation is both finite and ambiguous. The finitude comes from our embodied and temporally incarnated manner of living” (p. 418). In her weakness, Physio was able to strategize what she and her directors had to do to develop a policy for the future, thereby minimizing for others the kind of ambiguity she faced. Both Physio and the program directors had to learn to join forces to develop a new policy for this type of emergency situation. Physio shared, “It was not an easy thing to do. Pride got in the way. Nevertheless, we came together and wrote a policy.” In so doing, they committed themselves to improving the situation for those who would come to the program in the future.

It is communion like this, communication between people who may not always agree but who come together for the greater good of the community, that we are allowed the choice to become something greater than an isolated individual. Merleau-Ponty (1945/1962) sums up this idea, saying, “I may very well take myself away from the human world and set aside personal existence, but only to rediscover in my body the same power, this time unnamed, by which I am condemned to being” (p. 192). Although

no superheroes came to the rescue, Physio and her directors expressed an unnamed power, a great wisdom, when they came together in community to develop new policies for emergency situations. Physio stated, "These new policies will not prevent future emergencies from occurring, but may allow greater clarity for action during future emergency situations."

As they moved from a position of advisories to one of allies, Physio and her directors were forced to view one another in different ways, in new lights. On reflection, Physio said this:

> It is a difficult balancing act with a lot of balls to keep juggling. Cultural differences, a hospital for the poor, a sleuth of cultural issues, egos, and the hierarchy of the host organization all add to the lack of understanding protocol for rules of engagement. You realize that the host organization is flying by the seat of their pants and are then blaming you for not knowing. Suddenly you realize that you are all learning together. Life is a school and you as well as the host organization are all in this learning together.

Indeed, Macann (1993) suggests that being pushed beyond our limits through phenomenological reflection demands a transformation of our very being. We are thus reminded that "in learning how to *see*, we learn how to *be*, how to be something other than what we were when we remained blind to the new way of seeing" (Macann, 1993, p. 170).

Summary

The first constituent of not-knowing involves an initial experience of surprise and shock where even the tools of language are not helpful for the participants. Physical

therapists progress through a moment of paralysis by analysis described as feeling like a deer in headlights; feelings of self consciousness when experiencing the gaze of others; sensations of fight or flight as a call to focus; a moment of wondering what to do next; and a desire to be understood by others, culminating in the realization that they must do act.

Constituent Two: Strategizing and Improvising: On the Fly by the Seat of My Pants!

After focusing on what was happening and what needed to be done, the physical therapists in this study began to develop strategies. Time seemed to slow down, allowing for the therapists to strategize. Renee Claire said, "Whoa you think to yourself, trying to slow down time for you to think. You want to figure something out and put it all together. You need to solve this puzzle." All participants commented that before they could act, they had to figure out the rules of engagement. Andrew described doing just that when he focused on what was happening and what he needed to do. He stated, "You begin to develop strategies by planning possibilities in your head. You think about the next steps and develop Plans A, B, and C. You have to be flexible and think about possibilities."

Bambi recalled how she was teaching but at the same time thinking ahead and anticipating new strategies. Ella commented, "Before you act, you need to figure out the rules of engagement. It is okay to not have all the pieces of the puzzle before you act." Jack mentioned that he found creative solutions, despite a lack of resources. "You move case by case," he said. George simply stated, "You improvise!" This second constituent for the experience of not-knowing is represented by two sub-constituents which include

wondering about the rules of engagement and improvisation. They are discussed in the following sections.

What Are the Rules of Engagement?

A code of ethics essentially provides guidelines for professional behavior or rules of engagement. Not knowing what to do in an international setting can prove challenging for physical therapy professionals who need to draw on this code, however. Awareness of the professional code of ethics can raise a therapist's level of anxiety, not lessen it, if he or she is unsure about how to proceed in a moment of not-knowing. In an ambiguous situation, such as that of the ISL work environment, the professional must examine the rules of engagement in an effort to make sense of what is happening. Initially, the therapist may feel that something is not right at the ISL site, that those involved function and interact differently than according to ways familiar to the therapist. All of this may mean that the therapist is unable to determine how the professional code of ethics applies, if at all, and how it might help guide action.

An etymological search of the phrase "rules of engagement" reveals that it is linked to the verb disambiguate, meaning to "remove uncertainty of meaning" (Oxford Online Dictionary). A moment of not-knowing what to do may in fact entail the dilemma of a person having specialized knowledge but realizing that he or she is unclear about the rules of engagement that regulate the situation at hand. Hence, disambiguation is needed to resolve the conflict of not-knowing, clarifying or shedding light on a puzzling situation. Perhaps it is in this moment of not-knowing what to do that the physical therapists in my study had to face their epistemological limitations as they become stuck, despite their specialized knowledge.

Wilma described how she was working in a foreign health-care system that was clearly different from anything she had experienced in the United States. She was working as a consultant and physical therapist educator in a country in Eastern Europe. She had some difficulty in understanding a physical therapist's professional roles in that country because there seemed to be several different kinds of physical therapists. Physical therapy care appeared to occur in a fragmented system rather than in one that she considered integrated.

Wilma had been mindful that everyone's time, including her own, was a valuable commodity and had been working to be respectful of her colleagues in the host institution. Suddenly, she and another American colleague found themselves sitting behind the closed doors of a physician's office after being summoned with no idea of what is going on. Wilma struggled with the idea of wasting valuable time sitting in the office when she could have been productive, spending her time doing patient care, teaching, and modeling appropriate rehabilitation techniques. Wilma felt that her time had been taken from her as she had to sit and wait for the physician to return. Finally, the physician arrived and pleasantries began. Wilma described the situation:

> In the middle of a patient care session, I am suddenly pulled from my work. I am sitting there in this office with the doors closed with my colleague for maybe two hours before the physician came. One thing that took me by surprise and a little while to figure out was that there are going to be a lot of pleasantries. Before any business the pleasantries will include food and they might give you some cognac or some wine or champagne and then after you've done that then they just look you in the eye and there goes the business. So for us it's so opposite. It's so

> opposite of what I am used to. So to have wine first and then to have to be sharp, well, that was a little . . . . a bit interesting. [Laughter.]

Finally she was asked a direct question regarding a complex patient case. Wilma further explained:

> We're in the room consulting with the doctor and neither of us are pediatric therapists. We are in a pediatric setting and the doctor brings to us a child with what he believes has arthrogryposis and what do we think we should do for this child. You know, my brain is scrambling. And I feel just sort of a sense of wanting to help. Here are these people just looking for information. They're looking for information . . . . they're wanting to improve the quality of care and I want to help them do that. I am just going crazy in my head trying to think that I have just got to give them something. You know, at least move them in the right direction. And I don't want to just say, "Oh, I don't know." And so it's like something, something, there's got to be something—just let me find something. And so you know I feel comfortable prefacing it with something you know, "My experience is limited in this area, but here is what I can give you. Here's a start to move in the right direction." But yes, there is a lot of brain and emotional scrambling.

Similarly, Physio shared that her relation with her on-site program directors was strained after the emergency situation she faced with her bleeding student. The rules of engagement had simply not been clear:

> I realize that the director of the host organization has allowed me to be placed in such a reckless and helpless position. I am not privy to the organization's inner

> rules and procedures. How am I supposed to know the rules of engagement when valuable information is withheld from me? I reassure myself that I made a good decision and I continue to reflect on it. You know, I cannot blame myself because one cannot do what they do not know. I cannot act according to protocols that are not written. I struggle with how much planning I put into this trip and ask myself why I hadn't anticipated this problem as a possibility. You wonder why you didn't anticipate for accidents or bad things like this to happen. I also reflect on my professionalism.

When the rules of engagement are unclear, there comes a moment where a professional can put aside his or her sense of, or perception of, ambivalence in order to move forward from a moment of not-knowing. Perhaps these ideas of strategizing and improvising are best summed up in the following quotation from Merleau-Ponty (1946/1962):

> Perceiving is pinning one's faith, at a stroke, in a whole future of experiences, and doing so in a present which never strictly guarantees the future; it is placing one's belief in a world. It is this opening upon a world which makes possible perceptual truth and the actual effecting of a *Wahr-Nehmung* [sense, perception, or ambivalent perception], thus enabling us to 'cross out' the previous illusion and regard it as null and void. (pp. 346-347)

In summary, rules of engagement allow us to start with a plan. When we realize our rules of engaging will not work, we must move into improvisation where we begin to play with new ideas as our previous perceptions have become useless to our given situation.

Improvisation

Each of my participants spoke of the need to improvise during their call to action in their moment of not-knowing. The word *improvise* is a verb which means "to invent or make something, such as a speech or a device, at the time when it is needed without already having planned it" (Cambridge Online Dictionary). Word Central at the Merriam-Webster online dictionary provides another definition of *improvise*: "to compose, recite, play, or sing without preparation; to make, invent, or arrange on the spur of the moment without planning." An etymological search of the term *improvise* provides us with a greater understanding of its meaning. *Improvise* comes from the French word *improviser* and from the Italian word *improvvisare,* which is derived from *improvviso*, meaning sudden. The word is also linked to the Latin word *improvisus,* meaning literally unforeseen, from *in-* and *provisus.* Interestingly, the past participle of *providēre* means to see ahead (Merriam-Webster online dictionary).

Most of my participants spoke of the process of trying to figure things out "flying by the seat of my pants" or "on the fly" and "in the spur of the moment," in a setting with different languages, cultural norms, and unfamiliar behavior. Andrew stated, "I strategize in my head. I have to be flexible and even 'fly by the seat of my pants' thinking about possibilities. I have to be resourceful to figure it out." Describing the moment after being challenged by a physician, Kuzu explained, "I return to strategizing. I continue to replay the events in my mind and ask myself other questions. I ask myself what I missed." Donna improvised strategies in her mind doing the following:

> I begin strategizing despite having no concrete information on how to act. There is a conflict between wanting to be respectful and also wanting to be right. Yet you act out of a duty to your patient and hope for the best.

Isabel offered, "I search for creative solutions to my problem and try to test it against my previous experiences." Jan described how she attempted to strategize in her mind:

> I look at my options and wonder if it is better to cut my losses and retreat. I agonize on a cognitive level as I take stock of my situation. I am a problem-solving optimist. I prefer that role rather than feeling like a failure. I believe most things can be salvaged and I will not pass the buck. Things don't always go as planned.

George stated that he took the following approach in his moment of not-knowing:

> I was on unchartered territory but I had to make due. It is like I take a step into the deep and begin figuring things out. I am a professional. It is my job to figure it out. You strategize on how you're going to improvise. I try to create the situation I learned about in school but without having what I would normally be working with. I have to be resilient and think on my feet. I know I have to act.

Jillian suggested that talking to others helps her to improvise and make sense of situations of not-knowing in an ISL setting. In her experience, working in isolation was not always helpful. In our interview she stated, "Your past experiences don't work in this situation. You realize there is a disconnect. It is like talking to a brick wall." She preferred talking with others. WL also preferred to sort through her options, bouncing ideas off others and being creative in the use of limited resources and time. She stated, "My teaching role allows me to be able to ask questions to help sort through possible

solutions to the problem. You build networks of solidarity and getting better acquainted with others helps you develop a plan because you can all brainstorm and improvise solutions together."

Not all therapists found sharing ideas to always be useful. Katrina suggested that talking with others while she was strategizing was not always helpful, as they did not always understand the complexity of the situation she faced. She preferred to "think on my feet and be creative despite the limited resources." Vanessa stated:

> I clam up. I find my safe space like a turtle pulling into my shell. Here I can determine my next strategies or rules of engagement before I return to the situation. Some ask me if I am licking my wounds when in reality I am thinking about the words I will use as tools to learn more. I then reengage by asking questions.

No matter if the therapists thought through the problem alone or drew on others, all participants spoke of drawing on their past experiences, knowledge, and professional training in order to focus on and tap into a solution to the mystery they faced.

Moran (2000) describes a mystery "as a problem in which I myself am involved as opposed to an objective puzzle which simply can be solved" (p. 406). The work of Merleau-Ponty further emphasizes the particularities of a person's relation to the world and recommends "perception as a basis for studying complex issues such as the relation of humans to each other in language, culture, and society" (Moran, 2000, p.418). Merleau-Ponty (1964) states:

> The experience of perception is our presence at the moment when things, truths, values are constituted for us . . . it teaches us, outside all dogmatism, the true

> conditions of objectivity itself; that it summons us to the tasks of knowledge and action. (Merleau-Ponty, p. 25)

Many of my participants spoke of "stepping back" to make sense of the mystery, their moment of not-knowing what to do. They spoke of improvising strategies for engagement in their mind. These comments resonate well with Merleau-Ponty's thoughts on the difference between a virtual body and an individual's actual body. Moran (2000) explains this aspect of Merleau-Ponty's work on perception: "We have as it were a 'virtual body' or phenomenal body wherein we can explore movements before actually performing them and this 'virtual body' is correlated to a 'virtual space'" (p. 419).

In moments of not-knowing, my participants were able to step back mentally, emotionally, and cognitively from the actual moment of not-knowing, despite the limitations of physically not being able to do so. In the virtual world of the calm and focused mind, my participants explored their action plans before reengaging in the physical world and putting their solutions into motion. My participants were thus presented with the freedom to struggle and seek meaning in the present situation, despite the limitations and constraints imposed by the physical world of the ISL environment and my participants' understanding of it. My participants sought meaning, given their perception, in their ISL encounters with the unfamiliar. Describing Merleau-Ponty's notion of human freedom, Moran (2000) states the following:

> As part of this approach, Merleau-Ponty emphasizes the necessity to take human freedom into account. But our freedom is constituted by the way we live in and adapt to a world of meanings where the significance of those meanings has already been chosen for us in a certain way. Whereas Sartre had emphasized the

> absolute nature of human freedom in his famous slogan "we are condemned to be free", Merleau-Ponty prefers a somewhat modified version of this slogan: "we are condemned to meaning." (p. 420)

The idea of being condemned to meaning is perhaps the mystery to which my participants sought an answer. They were thrown into situations that they perceived as failing to match their past experiences. In trying to see a novel answer or solution, my participants had to figure out the rules of engagement and improvise on the spur of the moment in order to see ahead and to determine what to do, despite being faced with the unforeseen. In summary, determining the rules of engagement as well as using improvisation and strategizing were important tools the therapists turned to in order to make sense of their situations so that they could move forward into action.

Constituent Three: Professional Identity and Self-Doubt: I Feel Like an Imposter!

The moment of not-knowing for my participants transcended more than realizing that they did not have answers for the situations they had to face. These participants indeed had taken on the burden of being professionals with specialized knowledge serving the needs of others. In their moments of not-knowing, they felt that they did not measure up to the level of competence that was expected of them, a level that they felt was suddenly out of reach or unattainable. Feeling helpless and sensing that they were at risk of being seen as imposters, each physical therapist experienced moments of self-doubt during which they questioned their professional identities, calling, and vocation. This experience of self-doubt had implications for each physical therapist, ultimately defining the meaning of their personal existence. The sub-constituents of self doubt and not measuring up, questioning their vocation and carrying the burden of professional

competence, as well as avoiding the stigma of being considered an ugly American or arrogant Westerner are discussed in the following subsections.

Self Doubt: Not Measuring Up

The strategy of relying on past experiences did not seem to fully serve the physical therapists in my study as they faced moments of not-knowing during their ISL work. In fact, they reported being thrown into moments of self-doubt and feeling like imposters. Macann (1993) explains this conflicting feeling of having previous experience and not being able to use it in a new situation as he states:

> And where present experience seems insufficient to account for the organization of the perceptual field, memory is also drawn in to lend the mind and the support of past experience. But in order that memory should be of any assistance I must be able to recognize the present experience as one which can be referred back to a past expereince which it resembles in certain respects. (p. 166)

Merleau-Ponty (1945/1962) clarifies this, writing, "Thus the appeal to memory presupposes what it is supposed to explain: the patterning of data, the imposition of meaning on a chaos of sense data" (p. 23).

The physical therapists in this study experienced interpersonal communication, language, time, and relating to others in ways that were likely different in the ISL settings than they had in their home-country settings, and at times these differences triggered self-doubt. They reported that when they could not understand what was expected of them, they felt diminished in their abilities to function as professionals and to fulfill their duties. Physio described how she felt in her circumstances:

> You feel small, like a child in a dysfunctional family being told by the adults that what you have done is not right, yet you have not been provided with any guidelines or protocols for this situation. You have acted to the best of your abilities, in good faith, with the best interest of your student in mind. You know in your head and your heart that what you have done is right. Being told by members of the host organization in front of everyone present, even the hospital staff, that what you did was not right, is demeaning. You know you absolutely did not endanger your student by doing what you did. You feel like a child being scolded by adults and yet you are not a disobedient child. You are more like a misunderstood child, but one that no one will listen to in order to understand your point of view. No one cares. You are left in the company of the host organization feeling very much alone and isolated.

Jan described how the unnerving and expanding uncertainty challenged her clinical judgment and self-identity. She shared these feelings:

> You feel angry at being stuck between the situation and the responsibility you shoulder for a situation that is beyond your control. Your stress is rising. You feel like a loser or imposter. You don't want the students to lose faith in you or to think that you misrepresented the situation. You are conflicted about your place in time and space.

Vanessa, who was both a clinician and a researcher, described her moment of professional self-doubt when the medical tribunal she was facing did not approve of her style of working with infants and families in the rural regions of the South Pacific. She shared her story:

I got stuck by stepping on a few pediatricians' toes without knowing it or without realizing it, and I did not anticipate what would happen. We were just busy screening infants who were at risk for delayed development. What happened is the people I trained to see the babies became so knowledgeable about what a baby should do that the minute they saw the baby was having difficulty they would call us up and refer the baby to us, which had never been done there before even though we had direct access there in this country since 1980. We were referring all of the infants out and seeing them and then going back to the physicians most of whom were fabulous. But the guys at the tribunal did not like the idea that we would be picking these kids up in our community-based organization. So they said, "No you can't do those kinds of things. It's not valid" and stuff. And I got asked to present my stuff before a kind of medical tribunal who then outlawed my work. Well, that tribunal, they were very nice, but then I was totally unprepared for an attack. And so I said, "Well, you want to see my research? Can I show you the data?" But the bottom line was that they didn't believe that other people should be screening babies and I because I was so stressed out, because I was being attacked I didn't see that the bottom issue was that their egos were being walked upon. I had just created a system that didn't need them and they didn't want to hear the research. They just didn't want to hear it. So they made up their mind before I walked in. And I was really unprepared for the way that they attacked me. You know I become like the turtle. Head in. Tucked in and retreat until I can figure things out. They are the authoritarians, and you are told you can't do it. So stop. Period. So I think it affected me a lot in terms of my ability

> to think on the spot and defend myself and to feel like my professional talents were being recognized and valued. I felt small and worthless . . . until I became famous.

When past experiences are not sufficient to solve the problem at hand, physical therapists begin to doubt their training and knowledge. Doubt also consumes the therapists on a personal level where the weight of competence is questioned.

A Question of Vocation: Carrying a Professional Burden of Competence

All physical therapists in this study had completed the competitive process of gaining acceptance to physical therapy school; they had graduated and passed their national board exam for licensure. When faced with their moments of not-knowing, the participants spoke of how their previous training has not prepared them for everything. Andrew described it this way:

> You need to be professional and keep up a professional front. You are ready for battle. In having a professional mindset you do not throw up your hands. You wear the hat of a professional and have a responsibility to fulfill that role. You have a duty to act and to act in the right way. I focus on empathy, living the principles of beneficence, doing no harm, and the seven core values of our profession. I try to use the code of ethics as my rules of engagement but frustration sets in because I just don't know what to do.

Most participants echoed those words. Gary spoke of how he processed the challenge while at the same time asking himself, "What are my qualifications?" Isabel described engaging in a balancing act in which "you are wondering what is going on

trying to make sense of the situation and you are also carrying a professional duty regarding the responsibility for your students and others."

Jillian shared how she questioned herself and her professional identity after being asked to treat children next to a dead body in the corner of the orphanage; the burial truck had been unable to make it to the orphanage that day and yet the kids and workers had to carry on with their everyday activities. Maddie and George were asked to prepare a child's body for burial after there had been a violent worker strike in the city where they lived. Neither had ever had to participate in such a task before nor were they sure how they should proceed. Maddie said, "Nevertheless you realize you must do something. Your professional code of ethics will not let you stand by and do nothing and neither will your sense of human dignity. You do what needs to be done."

Many of the participants were asked to do things that were never addressed in the curriculum they had successfully completed during their physical therapy education. Katrina said that, while facing a perplexing situation and developing a plan, she recalled hearing "danger bells going off inside my head" as she wondered what to do and sought to reconcile her professional identity with the options she thought were available to her.

The physical therapists in ISL work settings shouldered high degrees of responsibility. Furthermore, they were seen as experts and, because they spoke a language foreign to their ISL settings, they were seen as having privileged knowledge. They were conscious of not wanting to be considered arrogant Westerners or ugly Americans. Their professionalism challenged them to be respectful and they were compelled to do the right thing. During the interview process, Kuzu described a situation she faced when working in Asia in a situation in which she was seen as the orthopedic

physical therapy specialist. She had been working with a patient when the American physician visiting the clinic sabotaged her work, openly claiming Kuzu was incorrect in her diagnosis of a patient with a rotator cuff problem. This American orthopedic surgeon then ordered a neurological conduction test without even considering if it was appropriate technology for the small hospital in this Asian village. She described the circumstances:

> Here I am saying the patient has an ortho problem but the physician—the orthopedic surgeon is saying it is a neuro problem. I am being trumped by this physician who is rude to everyone. My entire worth as a health-care professional is now questioned by others. It is an emotional experience and I cry on that one. I question my professional knowledge and ask myself, "What the heck? Why didn't I think of a possible cervical involvement? Why didn't I consider that?" I feel like an imposter. Any credibility I had is now shot down by this one encounter with a physician who appears to have a big ego and high arrogance index. Shoulders are complicated I admit, and I tell myself I am not doing a good thing here. I also measure myself against our professional core values and code of ethics. It even goes beyond this. I question my knowledge as a PT and who I am as a caring human being wondering if I measure up.

Eventually, Kuzu learned that she had been correct in her assessment of the patient. The staff members learned to ignore and endure the arrogant orthopedic surgeon because he was there for only a short-term assignment and often wandered off to sightsee. Kuzu was later empowered through her clinical work and teaching abilities, which reassured her that she was indeed worthy to be a member of the physical therapy profession. The

relationships Kuzu established with others in her ISL assignment also validated her in her own eyes as a caring human being.

Donna reflected on her moment of not-knowing in Asia when she discovered that a young boy who had just undergone surgery for his clubfoot had a far more serious neurological problem. Donna experienced a blow to her self-esteem and doubted herself as a professional and as a caring human being. She explained how she felt like a traitor to herself and her profession:

> I think it had a negative influence on my self-esteem in the way of how effective I was as a teacher and therapist. I wondered why these people were bothering to listen to me and what I actually brought to the situation. And then the other thing was that I also felt such empathy for this family, particularly the mother. She obviously had a lot of hopes and dreams for her child. And I was feeling almost like a traitor and very sneaky as I would try to use the therapy situations to get her to see what was actually going on with her child even though we did not have a formal diagnosis. You know, I was using her child in that way because the child and I had a very good relationship, which I felt guilty about as well. The child's mother would say, "Oh, he likes you and he wants to spend time with you." And all I was doing was trying to get him to do things that he couldn't do and would never be able to do just so his mother could see the truth. In fact, to his mother it was not an issue. It was, "Oh, he's just recovering." It was a hard time. I wasn't going to be there for the length of time that would allow me to, you know, help her see the truth.

Donna later found peace in her ability to share her stories with others; yet she could not help but wonder about what happened to this child in Asia.

After moving through feelings of vulnerability and hopelessness, the physical therapists faced struggles with their identities as professionals, and ultimately their identities as caring human beings. The fear of being seen as imposters led the physical therapists to question their professional and personal existence. Despite their successful professional lives back in the United States, they faced the new contexts of international settings. The very being of these physical therapists came now in question as they struggled to make sense of the new physical therapy rules of engagement. These rules were not limited to those regulating professional practice but also included those guiding cultural practices and interpersonal interactions. The participants were charged with knowing the customs and unwritten rules of new cultures, understanding how to gauge appropriate personal space, when to make eye contact, and how to speak to others. When unsuccessful, these physical therapists questioned their vocational calling. They also faced questions concerning their purpose, usefulness, and their very existence.

For these physical therapists, more than their personal being was at risk of exposure. Donna stated:

> I didn't want to be seen as a failure with these students. I had no idea of what was expected of me. I had worked in direct patient care before, but now I was seen as a teacher. There was more responsibility in my new role. There was a lot of learning for me definitely. I had only been a therapist for four years. I had done some supervision of students but my leadership experiences were still something I

needed to work on. Being in this new country made me feel alone and inadequate. And I was expected to know how to proceed.

Jan shared her fear of failure with the following words: “I didn’t want this experience to impact the students in such a way that they would never do pediatrics again just because of this one experience and my poor ability to act.” She also spoke about her desire to model good clinical reasoning and decision-making for her students, while providing compassionate care for her patients. Andrew shared his disappointment in himself as a professional as he reflected on his sense of professional accountability and responsibility. He stated, “Oh, geez! I should have anticipated this, but I didn’t.” All therapists interviewed had to act to avoid the risk of being told that they were inadequate or uncaring and to avoid the shame that might result if they were discovered to not know. Sally reported how her moment of not-knowing what to do for a patient led to shame as she states, “Professionally, I am walking around in a cloud of fog. It is a shameful feeling when I cannot fill the void of what needs to be done. Patient care certainly suffers. I wonder what I am doing here. Am I accomplishing anything or am I doing more harm?” Bambi also shared, “I felt remorse that maybe I couldn’t make things right.” Kuzu’s feelings of shame increased when she realized the arrogant physician she was working with saw how devastated she was by his response to her judgment. It is clear that the pressure to act as a caring professional is indeed a burden carried by my participants.

Ugly American—Arrogant Westerner

Their different appearances, languages, and ways of dressing set the physical therapists apart in their ISL work environments. Sally pointed out how her appearance as

a Nordic-looking woman gave her away as a foreigner in her community located in the Caribbean. Renee Claire shared that she didn't want to be perceived as the ugly American who thinks she knows everything, but that she nevertheless had important knowledge and skills to share. She stated, "You are seen as the go-to person. You also want to acknowledge the wisdom of your colleagues who were trained in country." Jan also spoke to this matter, noting how important it was to reinforce and support the local staff at her community sites. Joan spoke of how her team was dressed in their REI clothing while all the patients who came to see them were dressed spotlessly in their "Sunday best" clothing. Even when the women in Joan's group had to wear veils, they still stood out, given their white skin and causal manner of dress.

Relating to others in a foreign land was difficult for many participants. Vanessa shared what she struggled with in her new environment in the South Pacific:

> So where I'm stuck at is where the people I work with are hierarchical. The coordinator is more American, all the tall men are the leaders while everyone under the coordinator is from the local community. And I'm a woman. And so they tell me what to do even though I'm the one that's supposed to be creating how we're supposed to be doing our work. And then if I say, "Well I think that this will get us to the solution faster," they say, "We don't do that. We've never done that. We don't do things like that." So I am really stuck on this hierarchical model.

Donna realized that her foreign words held privilege as she searched for how to proceed with the young boy she was treating whom the physician had misdiagnosed. She stated:

> I didn't want to be the crazy, arrogant Westerner who came in and told everyone what to do. My being stuck turned into a cultural barrier. I very highly wanted to be respectful and I didn't want to be wrong. But it went beyond being right. I wasn't alone with the doctor. I was in the room where he was with another patient. So everyone was hearing this too and I didn't want him to lose face. I didn't at all know how to approach my interaction with him.

Choosing her words carefully, Donna thought through how she would talk to the doctor. She knew she must act and wondered if medical diplomacy would work. Armed with the truth that things would likely not improve for her young patient recovering from clubfoot surgery, Donna knew she had to talk to the surgeon and that she needed to find a private place to do so. She thought over these questions on how to proceed in order to avoid being seen as an arrogant Westerner:

> Would I be able to phrase the questions to this doctor in such a way that everyone could save face? More importantly, who would tell the family about the fate of their son and help them find a specialist? Was there even a specialist to be found?

Relating to others in situations never before experienced was a challenge for all participants. Many spoke of how they encountered new experiences outside the realm of physical therapy in the social and political arena that surprised and challenged them. Maddie and George shared how they regarded professional identity as linked to one's identity as a caring human being. In the city where they worked in Africa, the labor unions were so strong that it was difficult for the workers at the center not to participate in the strikes or the violence that was occurring throughout the city. George shared this:

> Many of the staff members are threatened if they do not participate. Their homes will be burnt to the ground. As a co-worker I want to be their friend and respect them, but I am not on their side. I am different. I am the white foreigner with privilege. Reaching out to them is hard. I am caught between defending both the management's standpoint and my sponsor's point of view. Maddie also had a tightrope to walk as their boss. I have also treated many of the striking workers at my clinic further clouding the rules of engagement. It is a time of strained relationships and trying to work despite the decisively established lines that are drawn in the community. You want to avoid being seen as that ugly, imperialistic Western foreigner.

George reported that the tensions calmed down after the strikes. Maddie and George were able to reconnect with the workers and even develop some good handling skills for the staff at the orphanage. It was a small but sustainable change for the orphanage.

All participants in this study acknowledged that they could not do everything for everyone. They had limited resources and faced so many needs. Nevertheless, they battled themselves inside their heads, wanting to but doubting that they could make things right all of the time. Jillian experienced her own set of worries:

> Although you feel a sense of hopeless, you do the best you can in a situation that is not ideal. You have to be creative with your experience and skills when you don't have materials. You move forward making the best decision you can. You also know your limits.

"These challenges spark your creativity and that is the reason you do this work. It is a calling or vocation," suggested Renee Claire. In the end, WL stated, "You don't want to

be an ugly American. You would rather be a different American. You want to be seen as one who cares." According to Thomas and Pollio (2002), caring is not something that one does for another. It is something that is co-created and negotiated in interaction with another person, a coordinated dance between two human beings in a specific relationship.

Merleau-Ponty (1945/1962) writes this:

> It is by communicating with the world that we communicate beyond all doubt with ourselves. We hold time in its entirety, and we are present to ourselves because we are present to the world. (p. 493)

When we are present to the world even a routine experience can be transformed into a moment of powerful, personal connection where "our job is not to look *at* the other as an object of concern, but *with* him or her at what is being talked about" (Thomas & Pollio, 2002, p. 23). Indeed, Merleau-Ponty writes, "The whole question is ultimately one of understanding what, in ourselves and in the world, is the relation between *meaning* and *absence of meaning"* (Merleau-Ponty, 1945/2005, pp. 497-498). In this way, the participants in this study were in search of new lenses which would allow them to make connections with others, so that in fulfilling professional duties they became co-creators of meaning along with those around them. This third constituent thus involves carrying the burden of identity where an underlying tension lies in resolving issues of self-doubt with professional competence against the background of being an outsider in the unfamiliar community in which the participants find themselves situated.

Constituent Four: Illumination and Clarity: When the Light Bulb Turned On!

When all seemed hopeless, the physical therapists were able to discover new ways of knowing because they were able to see more clearly a route to action. This process

seemed to be the result of reflecting on action while in action. Donald Schön (1983) has researched reflective practice for professionals. He suggests that reflection on practice while in practice involves specific steps of allowing oneself to experience surprise, puzzlement, or confusion in a situation. Schön (1983) further states:

> The practioner reflects on the phenomena before him, and on the prior understandings which have been implicit in his behavior. He carries out an experiment which serves to generate both a new understanding of the phenomena and a change in the situation . . . . He is not dependent on the categories of established theory and technique, but constructs a new theory of the unique case . . . . He does not separate thinking from doing, ratiocinating his way into a decision which he must later convert to action. (p. 68)

Andrew, Ella, Joan, and Renee Claire all spoke of the process of trying to figure things out "on the fly and in the spur of the moment" or while "flying by the seat of my pants." They were situated in settings in which different languages were spoken and in cultures whose norms of behavior were unfamiliar. Nevertheless, after some reflection on action while in action, they could clearly see what to do. They stated, "That's when the light bulb went on!" Andrew described his moment of seeing clearly this way:

> Suddenly a light bulb goes on and I see that something I thought of will work. I now know clearly how to proceed. It is an "aha" moment when my clinical thoughts and reasoning come together and work. No one gets hurt. It is the icing on the cake that helps me realize the importance of honoring my calling to the profession of physical therapy.

Renee Claire agreed, saying, "Suddenly I know what to do. It is like a light bulb that goes on helping me to see what to do. I notice a wheel chair in the corner of the room." Jan described her light-bulb experience:

> Suddenly you see clearly. You sense a shared familiarity or comfort in the air. A problem now becomes a new opportunity. An attitude of optimism takes over. Your comfort zone is stretched yet you come to value the new rich learning moment.

Bambi clarified her perspective:

> It is like moving through a maze. You have been trying to go one way but now you can't. You realize that there is nothing wrong with taking a different path and switching your plan. It is okay if the plan does not go exactly as you had originally anticipated. It is okay to switch gears because you are still going in the same direction moving forward toward your goal but in a different way than you expected. Knowing what to do now takes a huge burden off of me. My breathing even changes to a more relaxed pattern. I understand my limitations but decide to engage and do what I can.

Gary shared, "It is an eye opener. I make a decision searching for focus and a direction. It is like you are lost and then you find your way." Isabel elaborated:

> Suddenly things become familiar again. I know what to do. It is like arriving at my destination. It is a good feeling. The more experiences you have like this one, the more you trust that the situation will resolve itself and barriers come down.

This fourth constituent of not-knowing is represented by three sub-constituents. These sub-constituents include seeing the situation differently, seeing oneself in a new light, and seeing others in a new light. They are discussed in the following sections.

Seeing the Situation Differently

It was after the light-bulb experience that the therapists in this study were able to get over the initial shock of the situation and move into action. Physio described her take on the experience:

> It dawns on you that you are really responsible for everyone and if you are truly responsible, you need to understand exactly what needs to be done in various situations. You can see clearly what needs to happen next. It is an empowering moment. It is a hopeful moment.

Joan described her encounter of clearly seeing the metaphorical light in a literally dark room. She was being asked to treat a patient with tetanus. Joan wondered what others would think of her if she did not know what to do. In the dark and without the luxury of sight, Joan learned that her hands would not fail her:

> I walked into the dark, windowless room painted black. It was hot and sticky, and the smell of death pervaded the air. I had just been asked to treat this man with tetanus who was lying on a mattress on the floor in a windowless room painted black. I am unable to see clearly through the darkness and feel like the blind going by feel. Rehab in a dark, dark room is tricky. The room has been painted black to help patients avoid excruciatingly painful spasms that lock their bodies into grotesque grimacing positions. The patients in this room are like statues of humans unable to move. Lockjaw is real. I make my way around the room and

> the five other bodies lying on mattresses on the floor. My students follow close behind. There are not a lot of resources available, and I can feel the pressure mounting. I want to find a place to go and be alone to think, but there is no place to go. Oh, my gosh! I have no idea what to do. I've never seen or felt this before. It is so hard to be considered the one who must know. A panicked fight-or-flight response begins to take over my body. My emotions begin to take over, complicating my ability to think in a cognitive and professional manner. What will my students think if I cannot help this man? Worse yet, I wondered what if my treatment actually kills the patient?

Despite the darkness of the room, Joan stated, "I felt like a deer in headlights." Joan began to search through her past experiences to see if that would help her make sense of the unknown she was facing. Then she began to rely on her hands. Joan began to move slowly, hand over hand, going by the feel of the man's body responding to hers. Using her proprioceptive feedback and going by the feel of the patient's body under her hands, Joan tried one motion and realized it was not the way to go, since the man's spasticity increased. She then tried another motion and felt the tightness that was locking the man's body begin to melt away. Joan's teaching instincts began to take over, calming her racing heart and centering her mind. She described the moment:

> It is a miraculous moment, like the first time your patient wakes up from a coma. It is an art thing when you have your hands on a patient and you feel them respond to you as their muscles relax. This lesson I began to teach my students by laying my hands on theirs as together we freed our patient's body from the imprisoned posture of tetanus and worked to restore a human soul.

Andrew, Joan, and Vanessa realized that by taking a few long breaths they were able to gain clarity of mind. Joan stated, “I was able to let my instructor mode kick in.” Joan was able to ask her students what they thought would be the best thing to do for the young man with tetanus in the dark, black room. It was then that she realized that she was not a failure as an instructor and that she still retained her clinical hands-on skills, even though she had spent the last few years in the classroom.

Once the participants discovered new ways of knowing, they were able to see more clearly what to do. They moved into action and did what had to be done. A period of reflection on action occurred during the period of action itself, as well as after the participants resolved their situations. This ability to reflect during action may be due to the critical thinking training that the physical therapy professionals received during their clinical education internships. In the ISL settings, what were once problems were later seen through a new set of lenses or in a new light, illuminating new possibilities where before, none had been perceived. The participants moved from unfamiliar situations viewed to be lacking in possibility to new ways of seeing possibility. When this shift occurred, the participants moved out of isolation into communion and reciprocity with others in the situation. They experienced shared, peaceful familiarity and comfort with the situation.

All participants spoke of how “a light seems to go on in your brain and you can clearly see what to do.” The light my participants spoke of was not literal light, but what Macann (1993) speaks of as the “light of attention” (p. 167). Hence, in the experience of these participants, the light of attention was needed to bring the truth of the objective world into view, thus providing “meaning on the chaos of sense data” they perceived

(Macann, 1993, p. 166). Macann (1993) further states, “Moreover, for true communication to take place there has to be reciprocity” (p. 192). Finally, for the participants to engage in their world, a transformation had to occur where my participants had to move out of their perceived isolation and reach out to others in reciprocity. Andrew shared:

> My job is to find solutions to help people function better. It’s a part of connecting. It’s a part of living and dialoguing. It’s a part of becoming human. You know we all want to feel connected to others. We can’t do this when we isolate ourselves.

Joan describes the transformational moment of communion and reciprocity as being a miracle. She stated:

> An aha moment or comfortable feeling occurs, similar to a gentle stream, letting you know you are moving in the right way. You are doing something good. A connection is made between patient and therapist. It might be something like a gratifying smile from a patient as their body relaxes or when they walk for the first time. It might be that the patient is simply able to breathe better. It is an art thing when you have your hands on someone and you know they are relaxing. You feel their muscles. It is an art thing for people to respond to you. A miraculous moment like giving birth occurs.

For the participants in this study, the light of attention appeared to illuminate possibility that had not been previously visible.

Seeing Oneself in a New Light

Each participant spoke of becoming a changed person as a result of his or her ISL experience. Andrew, Bambi, Ella, Katrina, and Vanessa spoke of how it was their actual

moment of not knowing that allowed them to gain greater confidence in their everyday abilities as physical therapists. In their vulnerability my participants connected with others in new, unfamiliar, and authentic ways. In what they perceived to be a fragmented ISL setting, my participants gained strength and a greater purpose of being. Not only did the participants connect with other human beings, they also reconnected with themselves and their capacities to care. Participant Kuzu reflected on her trip to Asia:

> Despite the challenges faced, I am able to see myself as that whole person that others see in me. In the past I had previously built up walls, and I would not let people see me for who I truly am. I denied myself from being vulnerable. On this trip I was vulnerable and had to rely on others at times. In allowing myself to be vulnerable, I learned how generous others are. I now have the gift of not worrying if others will think less of me if I am vulnerable. I have come away stronger by allowing myself to experience vulnerability.

My participants also spoke of having their eyes opened to the effects of trauma and to the overwhelming nature of human suffering. These issues were not isolated events that my participants could turn their backs on. Instead, my participants spoke of being called into communion with others in a reciprocal relationship because of encountering new ways of seeing and knowing. Jillian described her response:

> I became a changed person because of my experience. I am transformed in some way by the experience. I have gained a different understanding of poverty and a profound sense of gratefulness for what I have. I have become inspired by the idea that I can work for change and that it is important to do so. It is worth it! I

> have also become more creative with my clients back home. I have learned how to advocate within the system and other ways of approaching people.

Joan experienced a similar transformation:

> The experience changes you. I now become angered by the disparities I witness and I want to learn more. I want to get to the root of the problems. Learning more about deep-rooted beliefs, arbitrary borders, and finding sustainable solutions to problems is now an important part of my being.

Jack shared his perspective:

> There is a hope that what we do through education will change things little by little. There is also the realization of the limits of what one can do. One must know their role. Many social problems go deeper than the absence of physical therapy services. Here is where the promise of hope is created through education which may hold the key to sustainable care and social change. Change may occur little by little.

For the participants in this study, the ability to see the situation differently allowed them to also see themselves in a new light. They moved away from self doubt into a greater appreciation of themselves as caring human beings.

Seeing Others in a New Light

Coming together in community involves moving from isolation into respectful communion with others. WL shared, "Respect is fostered when you come together in community. It is a positive experience when you realize that the quality of life of others is made better through education and in creating community." Finally, George shared his ideas:

Thinking back on my time in Africa, I realize that Maddie and I have had the opportunity of a lifetime despite the challenges and struggles we have faced. We have learned a lot about life and death here. We have learned about the strength of relationships and the importance of community despite the complexities of cultural taboos and another political system. We have been asked to do things in the name of human dignity, which extend beyond the scope of our physical therapy curriculum and the scope of physical therapy practice. It is our professionalism and compassion for human dignity which have allowed us to accomplish things we never imagined were possible through the experience of building community with others even when it clearly did not seem a possibility.

Articulating (naming) and implementing (living) a profession's core values are ways of defining a professional group's moral identity (Jensen, Gwyer, Hack & Shepard, 2007). The essence of the stories shared by my participants speak to more than naming and living the core values that define a physical therapist's moral identity. Through the delivery of physical therapy services in foreign countries though ISL work, my participants were able to come to know others and themselves better. Thus, moments of not-knowing are not something to be feared or dreaded. Instead, all a similarly situated person needs to do is to transcend him or her and any self-imposed isolation. Reaching out to others in reciprocity is not easy, as an exchange of oneself as currency in the transaction must occur in the process. Merleau-Ponty (1945/1962) explains what it means to reach out to others in reciprocity:

> You give yourself in exchange . . . . Your significance shows itself, effulgent. It is your duty, your hatred, your love, your steadfastness, your ingenuity . . . . Man is but a network of relationships, and these alone matter to him. (p. 530)

Summary

Illumination and clarity shed a new light on the situation of not-knowing. This light of attention allowed the participants in this study to see their situations, themselves, and others in a new light. My participants' experiences have raised the stakes on what living *Dasein* will mean in their—and our—everyday lives. In their moments of not-knowing, they learned how to be better practioners of life. Having effulgence means shining or being radiant. Merleau-Ponty (1945/1962) suggests that heroes are those who live out their lives *in relation* to men [others] and the world. [Italics added.] So must we. We must become everyday heroes and shine.

Section III: Personal and Professional Implications

We have more possibilities available in each moment than we realize.
Thich Nhat Hanh

Oftentimes when traveling and on assignment in an ISL work setting, physical therapists are unable to fully see and act because of their outsideness. They sometimes lack the ability to see clearly what to do in a given situation, and yet their words are regarded as holding privileged meaning. Others often look to them for answers. They are asked to act. At times, the fear of not knowing what to do acts as a veil, preventing them from moving into action because they cannot see how to proceed. At other times, the situation itself sets a mood whereby their ability to see possibility in the very moment is diminished. These moments are like detours or roadblocks in their journeys to connect with others.

Being a physical therapist in the ISL setting may actually entail the physical therapist failing to have all the answers. Instead of being called to be experts, they are called *into* community with those whom they serve. It is in their vulnerability that they gain the strength to reach out to others in a holistic and caring manner. In doing so, they bring hope to their patients and clients. In this way, they experience *Dasein*, or being-in-the-world. And they can see the transformation in their situations and in themselves.

In Chapter Six, I reflect on my research process, the strengths my study, and this study's implications for my profession, namely the physical therapy profession. I also consider some of my poststudy reflections on not-knowing and the possibilities for preparing future clinicians who must embody the ideals of a doctoring profession and become bearers of hope to others. In Chapter Seven, I reflect on living with not-knowing

and what doing so teaches both physical therapists and people in general about themselves as they are called into communities of hope with others.

Chapter Six

Poststudy Reflections

This study describes the experiences of physical therapists who chose to share their moments of not knowing what to do in the ISL work setting with me. The participants spoke in a compelling manner and openly described their moments of not knowing what to do or being stuck. For my participants, the structure of not-knowing included constituents of facing limitation and surprise or shock; moments of strategizing and improvising; facing professional identity and self-doubt; and eventually reaching a moment of illumination that provided clarity about how to proceed. Once the physical therapists were eventually able to clearly see what to do they were then able to freely move forward into action.

Why Study Not-Knowing in ISL Work?

My experiences in ISL work as a physical therapist and my involvement in my profession as an educator have caused me to wonder about learning and the role of not-knowing in learning and physical therapy work. I found these concepts intriguing and compelling. I had personally experienced not-knowing in my everyday clinical work in the United States; however, when I found myself in another country serving as a physical therapist, the intensity of not-knowing experiences seemed to expand to greater proportions. I often wondered why this was so and why I found these experiences so profound when I was working in the international setting. I also wondered if others had this experience.

According to Anderson-Nathe (2005), the willingness to discuss moments of not-knowing and the accompanying self-doubt is important for a number of reasons. He states that there is a myth of supercompetence that exists in the allied health professions that must be debunked. Unlike my study, his study focused on youth workers in the United States. I could find no articles addressing not-knowing in the physical therapy literature. Yet, this phenomenon exists, as borne out by those who were more than willing to share their stories with me. After speaking with other physical therapists who had done ISL work, it was clear that many had experienced moments of not-knowing and were willing to begin conversations on the matter. And I learned from my conversations with these other physical therapists who had practiced abroad that they were profoundly changed by their experiences of not-knowing. I wanted to know more about this transformative dimension of the experience of not-knowing in an ILS setting.

Even though physical therapists experience moments of not-knowing in everyday practice in the United States, I chose the international setting for this study because international settings can reveal much about new experiences and those who experience them. That is to say, while the experience of not-knowing generally teaches us something new about ourselves and the world we live in, experiencing not-knowing as a foreigner or outsider can force the experiencer to see the world—and himself or herself—through new eyes and in a new light in an especially forceful, obvious way. Indeed, I believe that the international setting allows physical therapists as professionals to encounter something that we may not see in ordinary, everyday activities of life.

When we move as strangers through cultures with which we are not fully familiar, something about the lifeworld becomes unmasked and reveals itself to us. For example,

in an international setting we are not as savvy about the unwritten cultural rules regulating behavior as we are in our homelands where we are the insiders. Things that normally work at home do not function in the same way in the ISL setting. We are forced to pay attention in new ways and to see ourselves differently. In effect, the ISL setting forces us to see things with new eyes. Moments of not-knowing educate us by freeing us from what we have learned in the past so that we may be taught by the present moment. We learn something new about ourselves and our world.

Moods: Understanding Not-Knowing and Ourselves

Thompson (2007) suggests that feelings of being stuck in a situation are as important as the circumstances themselves. In fact, the mood of the situation determines our ability to act or to see possibilities. As a moment of not-knowing unfolds, Thompson (2007) suggests that it, like a predicament, "is not only a set of circumstances that unfolds around us but also the mood that infuses a situation and our being-ness" (p. 108). Ciborra (2001) suggests that "moods are far from being just private states. They disclose the world; they set the stage for our encounter with the world" (p. 7). Personal moods may affect a person's ability to see and to know what to do in a given situation. The situations we find ourselves in also bring a mood to the moment or world in which we are situated. Even though we may be well prepared for the given situation through our training and past experiences, the mood of the moment may heighten our experience of not-knowing. In not knowing what to do, we are blinded to seeing our options or possibilities. Ciborra (2001) further states this:

> Moods provide the ground in which our encountering the world and defining the situation take place. We can seldom choose such a ground: rather we are thrown

> from it into the situation. Moods colour indelibly our being in the situation. They are like a fog, or a low cloud, coming from nowhere but giving an opaque tonality to the situation and our being in the situation itself. The most powerful moods attune us with the situation so strongly it almost seems there are no moods at all . . . . Moods are the fundamental ways in which we are disposed in such and such a way, they are not the direct consequence of our thinking, doing and acting: they are rather the presupposition, the medium within which those activities take place. (p. 7)

My participants spoke of having moments in which the mood of the situation seemed to change dramatically as they realized that something was not going as planned. They encountered something shocking, astonishing, or surprising, and they had to face their limitations. They experienced not-knowing. A moment of panic set in. Ciborra (2001) describes it this way:

> This ordinary way of understanding and acting in the world stops. The world overwhelms us. It stops appearing as a set of tools ready for use; we lack the time to implement our in-order-tos. Resources are not at hand; time is not available. We are lead [*sic*]to inaction or to engage frantically in whatever action comes to hand, after having quickly considered all possible alternatives and come to the conclusion that none will be successful. (p. 10)

As foreigners in ISL settings, we physical therapists stand out and don't always know how to be successful in our interactions with others. In the phenomenological study by Wu (n. d., www.phenonenologyoneline.com) on the lived experience of being a

foreigner, the author suggests that individuals have a greater awareness of themselves when situated in foreign lands:

> Like standing in front of a mirror, one notices a lot of things of oneself which one did not see before. A recognition of "me" occurs. This "me" is not the "self" one is familiar with. I am not only a stranger to others, but also becoming a stranger to myself. (p. 2)

Wu further describes how, when a person encounters a problem in an international setting, the burden of that problem becomes salient and action breaks down. In such instances, people have to take moments to step back and reflect. As foreigners, the "tailored-fit relationship between peoples' actions and their situations no longer exists" (Wu, n.d., p. 3), and individuals are puzzled by the situations they encounter. People may also experience conflicts in their self-identity that they must address. There is no way to retreat from the situation Wu mentions. This proved true for the participants in this study because their ordinary, culturally familiar social routines didn't fit in their new settings; yet they had to act.

Drawing on past experiences or on a previously compiled body of knowledge does not always serve the foreigner well and can lead to great stress. Yet it can also allow the person to reorganize his or her sense of self. These are times during which we foreigners who experience moments of not-knowing can become transformed by our situations and encounter opportunities to reorganize our worlds. These are times of profound potential change. For example, reexamining one's identity in the new light that emerges from these moments allows one to accept a new connection between one's present, past, and future existence. Thompson (2007) states, "We may surprise ourselves

with what we can do. We may discover our limits, our finitude. Perhaps we learn more than we bargained for or anticipated" (p. 109). Moments of not-knowing may actually interrupt our experiences of the world and "shake things up and enable us to 'find' ourselves and experience *Dasein*, 'being-in-the-world,' in a very real and visible way" (Thompson, 2007, p. 109).

Relationships: Outsideness and Insideness

The aim of phenomenology is to gain a deeper understanding of the lived experience of another person from a first-person point of view. In doing so, we invite others to share an experience or story with us. A phenomenological approach to research allows us to unmask the lifeworld's concealment, bringing its aspects and qualities to explicit scholarly attention (Seamon, n.d., www.phenoneonologyonline.com). Seamon further states that "two key phenomenological notions important here are outsideness and insideness, which are especially significant because they set up an immediate fusion between person and world" (p. 1). Furthermore, Merleau-Ponty (1945/1962) suggests that we perceive and make sense of the world through our bodies. It is through our embodied sense-making of our world that situations can become unclear when facing new contexts as outsiders.

The work of Merleau-Ponty centers on understanding the world as experienced by people with broken bodies or perceptual systems. My participants did not have broken bodies or disrupted nervous systems. But they came to their ISL work with the idea that they would function as professionals and with the understanding that they would live their lives a bit differently than they had previously. They did not expect to struggle with

their professional and personal identities when faced with not knowing what to do in professional circumstances.

In my present study, the notion of foreigner added a layer of complexity to the concepts of insideness and outsideness. Once an insider to this experience, through the use of phenomenology I was able to gain a first-person perspective as an outsider, as a foreigner. I witnessed the stories of my participants who had been literal foreigners in other countries. Although my participants had fairly well-established professional identities, they found being thrown into new environments in which they were no longer insiders was a challenge. They felt exposed and self-conscious. Many had to overcome the fear of failure. Heidegger (1971) states that by giving a "voice to how we think and feel, and making noticeable our authentic self by unmasking it in the open, can improve communication and our ability to touch others" (p. 138). Telling about events that happened to them as foreign outsiders, the participants were insiders of a unique experience and I the outsider, the listener.

Hearing and listening are never purely sensory acts, suggests Flickinger (n.d.) in her writings on therapeutic listening (www.pheonomenologyonline.com). Flickinger further states that how we listen depends on the way we stand in the world. How we listen also depends on the relationship we have with the one to whom we are listening. Flickinger writes, "By listening intently there is a potential for something deep and great to be known" (p. 2). When listening to the stories that my participants shared with me, the focus was no longer on me. Consequently, the distance between my participants and me was diminished when I engaged them by listening intently to their stories. I wanted to hear what they had to say at a deep level and to respond in a caring manner. I needed

to be available to listen to my participants so that they felt truly heard and so that I honored their humanity.

Finally, I feel a moral responsibility to share my participants' stories in an honorable way. In this study, I made every attempt to present the words of the participants as they spoke them to me. I hope that I have shared their stories in an interesting and compelling manner that honors my participants. I also hope that these stories will help others see more clearly what the experience of not-knowing might mean to them. Perhaps others can see not-knowing as an opportunity to learn more about other people and also about themselves. These situations, after all, provide us with opportunities "to touch and at the same time be touched" (Moran, p. 409) as we experience our insertion into the world. In these instances, we see and are seen though the experience of *Dasein*. Moran (2000) explains, saying, "Human being is 'Being-in-the-world'. Furthermore, it is not as if Dasein is somehow sitting side by side with the world. Dasein is world-involved, and as Heidegger will later argue, world-disclosing" (p. 233).

Strengths of the Study and Wondering About New Things

In reflecting on the research process, I recognize my study's many strengths. First, my research question and the research approach were compatible. I selected phenomenology as the ideal framework to address my question because using it allowed me to gain access to the lived experience of other persons from a first-person perspective. In this manner, I was able to look at the phenomenon of not-knowing with my participants rather than at my participants as they experience this phenomenon. Secondly, I conducted and transcribed all of the interviews myself. This process ensured

that all of the digital tapes and transcripts were handled consistently. In addition, transcribing all of the interviews myself allowed me to become very familiar with the texts. I found this familiarity helpful when I began to analyze the data for constituents.

I also believe that the preparatory work I did before I began the interviews strengthened my methodology. This preparatory work included completing a bracketing interview and reading supplemental information about interviewing people about sensitive topics. I also wrote in my journal about my impressions of the interviews both before and after interviews. Another strong point of my study was that I conducted all interviews in a face-to-face format with the exception of three participants whose second, follow-up interviews occurred via Skype. In either format, I permitted immediate clarification, as needed. Being able to conduct a second interview with my participants, either in person or by Skype, allowed me to probe the experience of not-knowing at a deeper level.

I also believe that my professional experience as a physical therapist who had participated in ISL work increased my comfort level with the experience under investigation and increased my participants' comfort levels when revealing these personally challenging experiences. It helped me build rapport with my participants and is therefore also another strength of this study.

I developed my inclusion criteria in a way that increased the variations of the descriptions that I received. I accepted both men and women into my study, which again added a rich dimension to my findings. Participants represented all roles in which physical therapists engage in their everyday practices; my participants were clinicians, educators, administrators, consultants, and researchers. This variability in professional

roles also strengthened my findings. Despite being members of the same profession, the participants performed different roles within that profession, providing a compelling richness of experiences that were shared. Ultimately, experiencing the common moment of not-knowing, despite their divergent roles, united these physical therapists.

Another strength was the fact that all the stories of not-knowing occurred within five years of the interviews, so the participants' recall was vivid and still quite clear. My participants weighed in on their calling to physical therapy and the need to act ethically while seeking an answer to their moment of not-knowing, as established by the profession's code of ethics. Regardless of the roles they fulfilled in the field of physical therapy, it was clear my participants felt bound by the profession's code of ethics because of the concern they expressed regarding the importance of doing the right thing.

A final strength of the study was that my participants were geographically diverse, coming from all regions of the United States. Four participants were foreign-trained therapists certified and licensed to practice in the United States. One was a Canadian-trained physical therapist practicing in Canada, while another was a Canadian-trained physical therapist practicing in the United States. Two were Dutch-trained physical therapists practicing in the United States. Again, this variety among participants provided a richness in narratives, which brought greater breadth to the study.

Although the individual stories shared in this study may not be generalizable across all physical therapists, the general structure of the experience is generalizable across physical therapists involved in ISL work. Through resonance rounds, my participants agreed that the general structure and its constituents resonated well with their experiences of not-knowing. Resonance rounds with other physical therapists not

interviewed in this study also suggested that my work is generalizable to physical therapists involved in ISL work, whether they were participants in this study or not. There was even a high level of resonance among some members of the helping health-care professionals, such as physicians, nurses, occupational therapists, and prosthetists, who had also engaged in ISL work.

Something I am left wondering about was that all participants described finding solutions to their moments of not-knowing, even in difficult situations. The participants described doing the best they could despite the circumstances, and always put positive spins on their stories, even while noting that they had faced crisis situations at times. I found this positive attitude interesting, and yet I wonder if there were ever any stories where a positive spin or perspective was not possible. Maybe it is simply the makeup of physical therapists; physical therapists are trained to see possibility in the face of disappointment. They are realists, but they are taught to bring hope to their patients and clients. I would hate to see physical therapists, as members of a healing profession, unlearn the characteristics of remaining positive and open while in search of improved functionality for their patients.

Finally, in their descriptions of not knowing what to do, the participants often used clichés to describe their experiences. The term, deer in headlights, appeared to be frequently used in the descriptions I received. Other clichés for strategizing and improvising included: thinking outside the box, thinking on your feet, a flash in the pan, on the fly, and winging my way through things. Probing for more details seemed to challenge my participants to find words to describe what they meant by the clichés they used. At times it was easy for the participants to describe their feelings in everyday

language. Other times the participants struggled to find words to explain what they meant. Perhaps the use of clichés robs us of being able to come face to face with our feelings. We then hide behind the veil of clichés which we are taught to use from past learning through our cultural existence. The use of these clichés may then obscure our possibility of experiencing *Dasein* in our everyday lives.

Implications for Physical Therapists

As suggested earlier, phenomenological research helps one understand the essence of an experience and gain a deeper understanding of human nature as a phenomenon is encountered. In the case of this study, the phenomenon encountered was that of physical therapists in ISL not knowing what to do in specific work-related circumstances. Physical therapists and international service providers are invited to reflect on the meanings expressed in this paper and consider how they might improve their practice. Below are some of my thoughts about what others might consider in order to improve the practice of physical therapy in ISL work.

Physical therapists and international service provider organizations can listen to physical therapists and their stories about engaging in ISL work. Themes that emerge from the stories when framed in terms of phenomenological research could be used to improve international physical therapy practice in general and the orientation sessions for ISL work in particular. The curriculum for physical therapy programs that provide international clinical internships could also be expanded to allow discussions on not-knowing and its importance in professional development. Workshops for preparing students and clinicians for international work may help prepare ISL participants for moments of not-knowing.

Preparing physical therapists to deal with different cultural and clinical challenges by providing clinical role modeling and strategies during moments of not-knowing would be helpful. Doing so prepares future ISL therapists for moments of uncertainty. Helping students and clinicians understand that they will not know everything reinforces the value of collaboration. Understanding the power of collaboration will move physical therapist professionals away from the pressures of silo practices which encourage the therapist to think that he or she must know everything. Phenomenology teaches us to be open to new ways of thinking. In this manner, optimal patient-centered care will permit all parties involved to be partners in solving health-care problems, where we as collaborators discover new ways of knowing.

Listening attentively to physical therapists about their ISL work experiences and the meanings they have constructed can help physical therapists care for patients, teach, administer, consult, and conduct research in a more sensitive manner. In addition to sharing information about the challenges of international work, organizations that host physical therapists in international settings may learn how to ease the transition into a new international environment of physical therapy practice. Engaging in a conversation about not-knowing and its constructed meaning is important, because it is in our willingness to share our challenges with others that we learn the most about ourselves as human beings. This approach to investigating the lived experiences of physical therapists resonates clearly with phenomenology. Creating dialogue with others about the meanings constructed from lived experiences adds voices to any conversation whose aim is understanding the issues of not-knowing in ISL work.

Finally, the study will encourage discussions about how to live life humanely. Physical therapists have a moral obligation to listen to their patients. In fact, in order to develop care plans that take into account the contexts of patients' lives, physical therapists must listen carefully to their patients and their stories. We therapists must know more than the details of a patient's medical condition. We must move away from the Nagi (1965) medical model of practice, which sees patients as broken entities with diseases that cause impairments and functional limitations. We must view our patients holistically. Being open to new models of practice such as the International Classification of Function Model (ICF), which views patients as whole beings, is the wave of the future for clinical practice. Using this ICF model allows us as physical therapists to focus on other contextual factors, such as environmental and personal situations that influence the ability of our patients to participate fully in society. It also allows physical therapists to enter the conversation currently being held by other health professions who presently use the ICF model. In this way, patients may encounter a more unified health care system.

Physical therapists in practice should be encouraged to conduct more phenomenological research. Serving in roles as clinicians, educators, administrators, consultants, and researchers, physical therapists have something more to learn from each other and the people with whom they interact. Individuals are linked through the bonds of humanity by interconnectivity. Interconnectivity draws us into relationships with others. As we bear witness to the lived experience of others, we must remember the connections we have to each other and the moral responsibility we have to reach out and make the world a more humane place for all. Building better relationships with people

working across cultures, whether here or abroad, is crucial in removing barriers that lead to isolation. In doing so, others may feel less isolated and more connected to each other as they engage with individuals and communities in societal participation.

Physical therapists also need to tell their stories and others need to hear them. In order to prepare future clinicians who embody physical therapy as a doctoring profession, we must examine the challenge of not-knowing when mastering not only the knowledge but also the interpersonal skills necessary to be a member of a doctoring profession that embodies caring and holistic practice.

Concluding Thoughts and Reflections

In conclusion, this study is important in that it documents the lived experience of physical therapists not-knowing when completing ISL work. This study also has implications for physical therapists practicing within the United States who must meet the demands of today's ever-changing and diverse health-care system in their everyday practices of rehabilitation. The findings of this study suggest that in the practice of physical therapy, as in life, our knowledge is finite, yet our abilities to think through a situation and apply our knowledge to new situations is perhaps what really defines us as professionals. The ability of my participants to accept being thrown into not-knowing situations and their ability to move forward into action with confidence provides hope to all who might experience not-knowing when caring for others.

Chapter Seven

Living With Not-Knowing

I came to this study from a clinical perspective, with a belief that true engagement or partnership with the patients we serve means learning about the context of their lives. In this chapter, I reflect on what I have learned about not-knowing, being called into community, and hope as I have taken my research journey. We physical therapists often do not truly know our patients and the contexts of their lifeworlds. We often times do not even know ourselves. But practicing according to a holistic, patient-centered model requires this. There is an essence of reciprocity that must occur in our relationships with our patients and in our relationships with the world. We cannot rely solely on a medical diagnosis to solve a patient's problem or puzzle. We must see our patients' essences, their wholeness.

In my training to become a physical therapist, several professors, clinical instructors, and mentors have profoundly influenced my development, my self-understanding, and my practice of physical therapy. These people spoke of the importance of getting to know ourselves, our patients, and their stories. Patients have answers; we just need to ask the right questions. Yet, this strategy of getting to know our patients holistically can be quite tricky when we do not completely know ourselves. Complicating matters in clinical practice, as physical therapists we often face time constraints and productivity issues in the workplace or service site. We must deal with

high expectations. Others expect us to have answers, whether we practice here or abroad. If we do not have the right answers, questions of our competence or credibility may arise.

My clinical experience as a physical therapist and an educator in ISL work has brought me to practice settings in homes, classrooms, clinics, and communities at local, national, and international levels. I have felt the great expectations of my patients and their families for what I might be able to offer them, despite the limited resources available and a possible dismal prognosis for a given patient's situation. At times, I could see clearly what to do. At other times, I was completely blindsided in ways similar to those described by my participants. There were times when I simply did not know what to do or how to proceed. I felt stuck and had many moments of not knowing what to do. These moments always involved a fleeting feeling of self-doubt. It always seemed that the moments in which I struggled were the most profound. Those moments of not-knowing were the times when I learned the most about my patients and myself.

In this study I have come in contact with physical therapists who have not always known exactly what to do in given situations. It was not that they were ill-prepared or incompetent; they were blind to the knowledge they needed in the moment. Sometimes there were situations that could not be fully resolved; no good solutions or responses were possible. In such cases, the therapists did the best they could, despite having the mood of the moment veil possibilities. Cultural differences also presented blocks, so that the participants could not always see or become easily aware of possible options.

Through the course of my research for this study, I have seen how these physical therapists struggled and found answers. Although I have seen them joyful in finding solutions to difficult and complex problems, I have also seen how they doubted

themselves and questioned themselves as they actively sought solutions for their moments of not-knowing. Listening to the stories of my participants permitted me to discover important elements of clinical reasoning and ways to reconcile self-doubt and professional identity when all seemed lost. These stories have inspired me and have encouraged me to continue to see not-knowing as an opportunity to learn and to be an advocate, an educator, and a clinician who remains open to the contexts of other people's lifeworlds. For me, empowerment means that we fundamentally become respectful beings-in-relation with one another so that we may see others and ourselves more clearly.

Historical, cultural, economic, social, and political contexts all serve to define, blind, and divide us at times. In framing how we see, these elements also cause us to experience not-knowing and isolation. We often fail to see the unique perspectives or connection between us and our shared, lived humanity. Whether in sickness or health, we fail to see others and ourselves in our wholeness. And we fail to see variation and opportunity. We have been taught to see with blinders on, and we physical therapists have been taught to use specific, familiar clinical decision-making processes to make sense of all complex medical issues we encounter. We have to be willing to unlearn what we have been taught. This process is not comfortable, nor is it easy. Peter Senge (1990) describes our predicament:

> From a very early age, we are taught to break apart problems, to fragment the world. This apparently makes complex tasks and subjects more manageable, but we pay a hidden, enormous price. We can no longer see the consequences of our actions; we lose our intrinsic sense of connection to a larger whole. When we try to "see the big picture," we try to reassemble the fragments in our minds, to list

> and organize all the pieces. But, as physicist David Bohm says, the task is futile—similar to trying to reassemble the fragments of a broken mirror to see a true reflection. Thus after a while we give up trying to see the whole altogether. (p. 3)

Lessons Learned

Several lessons emerged from the stories and reflections of my participants that have clear meaning for physical therapy practioners, the profession, and for organizations who sponsor ISL work. From the narratives in this study, it is clear that not-knowing is a normal and even expected experience of ISL work. The first encounter with not-knowing may cause physical therapists to question their calling and may give rise to self-doubt. However, physical therapists in ISL settings cannot avoid not-knowing and should not fear it. Learning, identity, and beliefs go hand in hand. Our beliefs determine how we will be inclined to act in a given situation (Ross, 1994). The pressure of being and embodying competence as part of a caring professional may be at the core of the unrealistic expectations placed upon physical therapists involved in ISL work. Even when we do not know, we are still caring and competent clinicians. We are not imposters. We must never give up. Phenomenology itself holds potential for offering the field of physical therapy and ISL work an opportunity to refine its practice and become more caring.

Another lesson that not-knowing may teach us is to pay attention to and question our own beliefs. Many participants spoke of being able to recognize the bodily sensations of being placed in a situation in which they did not know exactly what to do next. When the focus of the moment was on them, they could only see a fragmented

view of the situation. They failed to see a true reflection of the moment. In reaching out to patients and others, my participants were able to make sense of the broken fragments of the glass through which they were peering. Moments of not-knowing then may actually pull physical therapist clinicians from an isolated position of doing things to patients into one of mutuality and reciprocity, of working with patients. In such a scenario, physical therapists and patients exist with each other and the relationship holds the potential for greater understanding. Heidegger (1927/1962) suggests that the hermeneutic circle is always open. In this way, others have an opportunity to enter into the conversation as we care for them, other people, and ourselves. Physical therapists are now invited into the ongoing dialogue about the phenomenon of not-knowing and what it might mean in their everyday practice of physical therapy.

Concluding Reflections

I have provided a rationale for the importance of physical therapists sharing their stories of not-knowing with others. Doing so gives people outside of an experience the opportunity to better understand what an experience is like. When an experience such as not-knowing is better understood, people outside that experience will be better prepared to provide care in a culturally competent manner. Recognizing the physical, emotional, and cognitive aspects of not-knowing will help others identify similar aspects in their own experiences, recognizing what they share rather than emphasizing the differences between themselves and others.

Furthermore, understanding the dynamics of not-knowing provides others with a more complete picture of the situation under consideration and promotes strategies or solutions for how to proceed. With the rise of and emphasis on interdisciplinary and

transdisciplinary work in health care, understanding the experience of not-knowing may help others in the health professions work collaboratively, in more open environments in which they may begin conversations about not-knowing and become receptive to different ways of knowing.

In conclusion, this study is important in that it documents the lived experience of physical therapists not knowing what to do during ISL work. This study may inform programs that use physical therapists in both local and global settings about how to prepare therapists for not-knowing experiences in new environments while on international assignment. It provides a rationale for programs and institutions to establish systems for networking or mentoring new physical therapists. It provides grounds for creating opportunities for physical therapists to share stories of not-knowing in an effort to decrease the burden of always having to know. Finally, this study also has implications for physical therapists practicing within the United States who must meet the demands of today's ever-changing and diverse health-care system in their everyday practices of rehabilitation. All physical therapists may see their moments of not-knowing as opportunities to ask questions and learn about others who hold different beliefs and to challenge the current medical model.

These findings are intended to stimulate further discussion about the possibilities that exist for changes in physical therapy practice and education. The general structure and the constituents that emerged help us better understand the experience of not-knowing. This understanding can now serve as a cornerstone to building better relationships with people who are involved in health care across cultures and across nations. In better understanding others, we will increase our sense of community with

each other. Physical therapists who experience moments of not-knowing may surprise themselves and others with what they can do. When we discover our limits, we discover something about who and how we really are in this world.

My work as an educator and clinician has allowed me to blend my interests in physical therapy, global health, and community engagement into meaningful work that encourages participation in communities for an ongoing, lifelong, transformative education. When we participate in another person's transformation, we often focus only on the destination, on the newly transformed person's improved state. We fail to see how we are transformed by the journey. It is clear that a calling to physical therapy expands beyond the classroom or clinic into social responsibility, which mandates bringing hope to others. The wisdom of the following Haitian proverb speaks to the message behind the work done when one follows their calling. Here, physical therapy work in the area of ISL means much more than simply teaching a class, improving another's movement pattern, understanding a community, or doing research. It means living the ideals of bringing hope to others so that they and we will see possibility.

Lespwa fe viv: hope makes us live.

References

Altrows, J. (n.d.). *Feeling like an imposter.* Retrieved December 17, 2009 from http://www.phenomenologyonline.com/articles/altrows.html

American Physical Therapy Association (APTA). (2003a). *Guide to physical therapy practice.* (2nd ed.). Alexandria, VA: American Physical Therapy Association.

American Physical Therapy Association (APTA). (2003b). *Professionalism in physical therapy: Core values.* Retrieved March 21, 2009 from http://www.apta.org/AM/Template.cfm?Section=Professionalism1&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=303&ContentID=35257

American Physical Therapy Association (APTA). (2004). *A normative model of physical therapist professional education: Version 2004*. Alexandria, VA: American Physical Therapy Association.

American Physical Therapy Association (APTA). (2007). *Vision 2020*. Web page. Retrieved October 10, 2006 from http://www.apta.org/AM/Template.dfm:Section=About_APTA&/Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=41&ComtentID=23725

American Physical Therapy Association (APTA). (2008, July 8). *APTA endorses world health organization ICF model.* Retrieved November, 30, 2009 from http://www.apta.org/AM/Template.cfm?Section=Home&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=50081

American Physical Therapy Association (APTA). (2008a). *Code of ethics.* Retrieved March 20, 2009 from

http://www.apta.org/AM/Template.cfm?Section=Core_Documents1&Template=/CM/HTMLDisplay.cfm&ContentID=25854

American Physical Therapy Association (APTA). (2008b, December). *Resource guide for international service-learning education programs*. (3rd ed.). Retrieved March 25, 2009 from http://www.aptahpa.org/associations/9956/files/CCISIGServiceLearningGuide12-1-08.pdf

American Physical Therapy Association (APTA). (2009a). *Background sheet.* Retrieved November 09, 2009 from http://www.apta.org/AM/Template.cfm?Section=About_Physical_Therapy&TEMPLATE=/CM/HTMLDisplay.cfm&CONTENTID=33205

American Physical Therapy Association (APTA). (2009b). *New code of ethics.* Retrieved November 17, 2009 from http://www.apta.org/AM/Template.cfm?Section=Ethics_and_Legal_Issues1&Template=/CM/ContentDisplay.cfm&ContentID=63686

Anderson-Nathe, B. (2005). Not knowing what to do: Youth workers' experiences of being stuck (Unpublished doctoral dissertation). University of Minnesota, Minneapolis, Minnesota.

Barritt, L., Beekman, T., Bleeker, H., & Mulderij, K. (1983). Analyzing phenomenological descriptions. *Phenomenology + Pedagogy, 2*(1), 1–17. Retrieved from http://www.phenomenologyonline.com/articles/articles.html

Benner, P. (2001). *From novice to expert: Commemorative edition.* Upper Saddle River, NJ: Prentice Hall Health.

Blau, R., Bolus, S., Carolan, T., Kramer, D., Mahoney, E., Jette, D. U., & Beal, J. (2002). The experience of providing physical therapy in a changing health care environment. *Physical Therapy, 82*(7), 648–657.

Briggs, C. L. (1986). *Learning how to ask: A sociolinguistic appraisal of the role of the interview in social science research.* Cambridge: Cambridge University Press.

Brown, M. M. (1989). What are the qualities of good research? In F. H. Hultgren & D. L. Coomer (Eds.), *Alternate modes of inquiry in home economics research. Yearbook 9, American Home Economics Association* (pp. 257–297). Peoria, IL: Glencoe Publishing Company.

Buber, M. (1958/1986). *I and Thou.* (R. G. Smith, Trans.). New York: Charles Scribner's Sons.

Bucholtz, M. (2000). The politics of transcription. *Journal of Pragmatics, 32,* 1439–1465.

Ciborra, C. U. (2001). *In the mood for knowledge.* Retrieved December 17, 2009 from http://www.lse.ac.uk/collections/informationSystems/pdf/events/2001/ciborra.pdf

Colaizzi, P. F. (1978). Psychological research as the phenomenologist views it. In R. Valle & M. King (Eds.), *Existential-phenomenological alternatives for psychology* (pp. 48–71). New York: Oxford.

Compact English Oxford Dictionary. Retrieved November 9, 2009 from http://www.askoxford.com/concise_oed/etymology?view=uk

Dahlberg, K., Drew, N., & Nyström, M. (2001). *Reflective lifeworld research.* Lund, Sweden: Studentlitteratur.

Death & Einstein. In *Reference.com*. Retrieved Dec. 4, 2009 from http://ask.reference.com/related/Who+Said+Time+Waits+for+No+Man?&qsrc=2892&l=dir&o=10601

Dent, J. M. (1956/1993). Everyman. In A. C. Cawley, (Ed.), *Everyman and medieval miracle plays.* (pp. 195-225). London: Orion Publishing Group.

Devault, M. L. (1990). Talking and listening from women's standpoint: Feminist strategies for interviewing and analysis. *Social Problems, 37*(1), 96–116.

Edwards, I. & Jones, M. A. (2007). Clinical reasoning and expert practice. In G. M. Jensen, J. Gwyer, L. M. Hack, & K. F. Shepard (Eds.), *Expertise in Physical Therapy Practice.* (2nd ed.), (pp 192–213). St. Louis, MO: Sanders Elsevier.

Einstein, A. (1920/2006). *Relativity: The special and the general theory*. New York: Penguin Classics.

Elstein, A. S., Shulman, L. S., & Sprafka, S. A. (1978). *Medical problem solving: An analysis of clinical reasoning.* Cambridge: Harvard University Press.

Epstein, R. M., & Hundert, E. M. (2002). Defining and assessing professional competence. *JAMA, (287)*2, 226–235.

Flickinger, A. (n.d.). *Therapeutic listening.* Retrieved December 17, 2009 from http://www.phenomenologyonline.com/articles/flickinger.html

Fontes, L. A. (2008). *Interviewing clients across cultures: A practioner's guide.* New York: The Guilford Press.

Gadamer, H-G. (1960/1995). *Truth and method.* (2nd rev. ed.). (J. Weinsheimer & D. Marshall, Trans.). New York: The Continuum Publishing Company.

Giorgi, A. (1975). An application of phenomenological method in psychology. In A. Giorgi, C. T. Fischer, & E. L. Murray (Eds.), *Duquesne Studies in Phenomenological Psychology* (Vol. 2) (pp. 82–103). Pittsburgh, PA: Duquesne University Press.

Giorgi, A. (1997). The theory, practice and evaluation of the phenomenological method as a qualitative research procedure. *Journal of Phenomenological Psychology, 28,* 235–260.

Gold, H. (2009, November). Paved with good intentions: In Haiti no good deed goes unpunished. *The Rotarian.* 42–47.

Heidegger, M. (1927/1962). *Being and time* (J. Macquarrie & E. Robinson, Trans.). New York: Harper & Row.

Heidegger, M. (1959/1971). *On the way to language* (P. Hertz, Trans.). New York: Harper & Row.

Hostetler, K. (2005). What is "good" education research? *Educational Researcher 34*(16), 16–21.

Husserl, E. (1964). *The idea of phenomenology* (W. P. Alston & G. Nakhnikian, Trans.). The Hague: Martinus Nijhoff.

Husserl, E. (1970). *The crisis of European sciences and transcendental phenomenology: An introduction to phenomenological philosophy* (D. Carr, Trans.). Chicago, IL: Northwestern University Press.

Hiller, P. H., & Swisher, L. L. (2009). *An update on proposed revision to APTA core ethics documents.* Presented at the March 20, 2009 Florida Physical Therapy Meeting, Orlando, FL. Retrieved November 6, 2009 from

http://www.apta.org/AM/Template.cfm?Section=2005_Motions_Reports&Template=/MembersOnly.cfm&ContentID=58620

Illich, I. (1968). *To hell with good intentions*. Retrieved November 17, 2009 from http://www.swaraj.org/illich_hell.htm

Improvise. (n.d.). In *Cambridge online dictionary*. Retrieved December 5, 2009 from http://dictionary.cambridge.org/define.asp?key=39575&dict=CALD

Improvise. (n.d.). In *Merriam-Webster's online dictionary*. Retrieved December 6, 2009 from http://www.merriam-webster.com/dictionary/improvise

Improvise. (n.d.) In *Word central online*. Retrieved December 5, 2009 from http://www.wordcentral.com/cgi-bin/student?book=Student&va=improvise

Jensen G. M., Gwyer, J., Hack, L. M., & Shepard, K. F. (2007). *Expertise in physical therapy practice.* (2nd ed.). St. Louis, MO: Sunders Elsevier.

Kendall, J. C. E. (1990). Combining service and learning: An introduction. In J. C. E. Kendall, Ed. *Combining service and learning: A resource book for community and public service.* Vol I. Raleigh, NC: National Society for Experiential Education, 1–33.

Kirsch, N. R. (2009a, October). *Bringing us up to code.* Ethics in Practice. APTA PT in Motion. Retrieved November 6, 2009 from http://www.apta.org/AM/Template.cfm?Section=Archives3&Template=/MembersOnly.cfm&CONTENTID=64644&NAVMENUID=3370&DIRECTLISTCOMBOIND=D&Token=7BF824C1-E368-4C36-B15F-80577F57F344

Kirsch, N. R. (2009b, November). *New and Improved.* Ethics in Practice. APTA PT in Motion. Retrieved November 6, 2009 from

http://www.apta.org/AM/Template.cfm?Section=Archives3&Template=/MembersOnly.cfm&NavMenuID=3377&ContentID=65689&DirectListComboInd=D

Know. (n.d.). In *Merriam-Webster's online dictionary*. Retrieved December 17, 2009 from http://www.meriam-webster.com/dictionary/know

Lyneham, J. Parkinson, C., & Denholm, C. (2008). Explicating Benner's concept of expert practice: Intuition in emergency nursing. *The Journal of Advanced Nursing, 64*(4), 380–387.

Macann, C. (1993). *Four phenomenological philosophers.* London: Routledge.

McClelland, J. (1995). Sending children to kindergarten: A phenomenological study of mothers' experiences. *Family Relations, 44*(2), 177–183.

Medical Dictionary Online. Retrieved July 7, 2008 from http://medical-dictionary.thefreedictionary.com/profession

Merleau-Ponty, M. (1945/1962). *Phenomenology of perception* (C. Smith, Trans.). London: Routledge & Kegan Paul.

Merleau-Ponty, M. (1964). *The primacy of perception.* (J. Edie, Ed.). Evanston, IL: Northwestern University Press.

Merleau-Ponty, M. (1973). *The prose of the world* (J. O'Neill, Trans.). (C. Lefort, Ed.). Evanston, IL: Northwestern University Press.

Merriam, S. B., Caffarella, R. S., & Baumgartner, L. M. (2007). *Learning in adulthood: A comprehensive guide.* (3rd ed.). San Francisco, CA: Jossey-Bass.

Mezirow, J. (2000). *Learning as transformation: Critical perspectives on a theory in progress.* San Francisco, CA: Jossey Bass.

Moran, D. (2000). *Introduction to phenomenology.* New York: Routledge.

Nagi, S. (1965). Some conceptual issues in disability and rehabilitation. In M. Susman (Ed.), *Sociology and Rehabilitation.* Washington: Institute of Medicine National Academy Press.

Norman, G. R. (1985). Defining competence: A methodological review. In V. R. Neufeld & G. R. Norman (Eds.). *Assessing clinical competence*. New York: Springer Publishers.

Oxford Online Dictionary. Retrieved July, 7, 2008 from http://www.askoxford.com/concise_oed/profession?view=uk

Peace Corps. (n.d.). *Culture matters: The cross-cultural workbook.* Retrieved December 7, 2008 from http://www.peacecorps.gov/multimedia/pdf/library/T0087_culturematters.pdf

Pechak, C. M., & Thompson, M. (2009). A conceptual model of optimal international service-learning and its application to global health initiatives in rehabilitation. *Physical Therapy 89*(11), 1192–1204.

Polkinghorne, D. (1989). Phenomenological research methods. In R. S. Valle & S. Halling (Eds.), *Existential & phenomenological perspectives in psychology: Exploring the breadth of human experience* (pp. 41–62). New York: Plenum.

Polkinghorne, D. (2003a). Generalization and qualitative research: Issues of external validity. In J. Linden & P. Szytek (Eds.), *Validation of knowledge claims in human science* (pp. 121–163). Lyon: L'Interdisciplinaire.

Polkinghorne, D. (2003b). Validation in physical, organic, and human realms. In J. Linden & P. Szytek (Eds.), *Validation of knowledge claims in human science* (pp. 11–24). Lyon: L'Interdisciplinaire.

Raatikainen, R. (1997). Nursing care as calling. *Journal of Advanced Nursing, 25,* 1111–1115.

Ross, R. (1994). The ladder of inference. In *The fifth discipline field book*. (p. 242–246). New York: Doubleday.

Rosenblatt, P. C. (1995). Ethics of qualitative interviewing with grieving families. *Death Studies, 19,* 139–155.

Sartre, J. P. (1947–1976). *Situations.* I–X. Paris: Gallimard.

Schön, D. A. (1983). *The reflective practioner: How professionals think in action.* New York: Basic Books.

Seamon, D. (n. d). Phenomenologies of environment and place. *Phenomenology + Pedagogy, 2*(2), 130–135. Retrieved December 17, 2009 from http://www.phenomenologyonline.com/articles/seamon.html

Senge, P. M. (1990). *The fifth discipline: The art and practice of the learning organization*. New York: Doubleday/Currency.

Seifer, S. D. (1998). Service-learning: Community campus partnerships for health professions education. *Acad Med. 73*(3) 273–277.

Shepard, K. F., Jensen, G. M., Schmoll, B. J., Hack, L. M., & Gwyer, J. (1993). Alternative approaches to research in physical therapy: Positivism and phenomenology. *Physical Therapy, 73*(2), 34–47.

Thomas, S. P., & Pollio, H. R. (2002). *Listening to patients: A phenomenological approach to nursing research and practice.* New York: Springer Publishing Company.

Thompson, T. L. (2007). Finding ourselves in a predicament: Now what do I do? *Phenomenology & Practice, 1*(1), 97–112.

Van Engen, J. A. (2000, January–February). The cost of short term missions. *The Other Side,* 20–23.

van Manen, M. (1997). *Researching lived experience: Human science for an action sensitive pedagogy.* (2nd ed.). London, Canada: Althouse Press.

Vanderhoff, M. (2005, May). Service learning: The world as the classroom. *PT: Magazine of Physical Therapy, 13*(5), 34–41.

Wahr-Nehmung. Improvisation. In *German-English dictionary.* Retrieved December 2, 2009 from http://dict.tuchemnitz.de/dings.cgi?lang=en&service=deen&opterrors=0&optpro=0&query=Wahr-Nehmung&iservice=&comment=&email=

Walker, W. (2007). Ethical considerations in phenomenological research. *Researcher, 14*(3), 36–45.

West, C. (1996). Ethnography and orthography: A (modest) methodological proposal. *Journal of Contemporary Ethnography, 25*(3), 327–352.

World Confederation for Physical Therapy (WCPT). (2008, June 17). *APTA endorses ICF.* Retrieved November 24, 2009 from http://www.wcpt.org/smfforum/index.php?board=48.0

World Health Organization (WHO). (2001). *International classification of functioning, disability, and health: ICF.* Geneva, Switzerland.

Wu, Z. *The lived experience of being a foreigner.* Retrieved December 17, 2009 from http://www.phenomenologyonline.com/articles/wu.html

Appendix A: Participant Recruitment Flyer

An opportunity to share your story . . .

You are invited to participate in a study on:

The lived experiences of physical therapists "being stuck" or not-knowing what to do during an international service-learning experience.

Study involves:

- An opportunity to share your story
- 2 short interviews
- No compensation

If interested, contact:

Sue Klappa, PT, MA
(952) 935-0486 home
(651) 690-8131 work
Email: Klap0033@umn.edu

Appendix B: Consent Form

Not knowing what to do: Experiences of physical therapists "being stuck."

Investigator: Sue Klappa, PT, MA . . . . 651-690-8131 or klap0033@umn.edu

Please read this document and ask any questions you may have before agreeing to be in the study. The researcher is Sue Klappa, who is a physical therapist and graduate student at the College of Education and Human Development, Curriculum & Instruction Department in Family, Youth, and Community at the University of Minnesota. This study is primarily for partial fulfillment of the requirements for a Ph. D. Degree.

You are invited to be in a research study about the experience of physical therapists who experience moments of not knowing what to do or "being stuck" during an international service-learning trip. You were selected as a possible participant because of your past involvement in an international service- learning trip.

Background Information:
The goal of this project will be to learn about the experience of not knowing what to do or "being stuck" when functioning in the role of a physical therapist working with a team of other health care professionals and/or students during an international service-learning trip. The results may help us better prepare physical therapists who will engage in an international service-learning experience.

The guiding research question is: What is the experience of not knowing what to do or "being stuck" during an international service-learning experience for physical therapists?
Procedures: You will be asked to do the following things during this study.
If you agree to be in this study, we would ask you to do the following: Be interviewed two times. The first interview will take about 45 – 60 minutes and will be audio recorded. It will involve talking about instances during an international service learning experience where you felt stuck or did not know what to do. A second interview will be conducted to clarify that I have indeed captured the essence of your story. This interview will last approximately 30 minutes.

The interviews will be held at a mutually agreed upon time and location. If you are not available for a second in-person interview, then a phone interview will be arranged.
The only direct benefit of your involvement in this research study is that you will be allowed to share your story.*You will not be paid for participation in this study. You will not be reimbursed for travel expenses to the interviews.

Risks and Benefits of Being in the Study:
Participation in this study does not involve any physical risk. The study has minimal risk. You might be asked to remember experiences that might make you feel bad. The University of Minnesota does not provide medical services or financial assistance for injuries that might happen because you are taking part in this research. You may withdraw from the study at any time without adverse consequences. You may end the interview before completion, refuse to answer any questions, or refuse to participate in the follow-up interview/phone calls/emails. You may ask that data from your interview be withdrawn from the study.

Confidentiality:
The records of this study will be kept private. Any personal identity such as your name, place of employment, location of international involvement, etc. will be kept anonymous. In the report I write, I will not include any information that will make it possible to identify you. You may in fact choose a pseudonym for your name.

After graduation, I hope to be able to publish the results of this project. Again, pseudonyms for you, your university or employment organization, your community partner organization rather than real names will be used. Only the investigator and her advisor/professor will have access to the transcripts. Tapes and notes will be maintained in a locked bag during travel. The tapes, hard copies of the transcripts will be erased, and the hard copies of the transcripts will be stored in the locked desk drawer of the investigator. Hard copies of the transcripts will be shredded after 5 years.

Voluntary Nature of the Study:
You have the ultimate right to deny participating in this study or to withdraw from this study after you have agreed to participate at any time of your choice during the study. You also have the right not to answer questions posed to you by the researcher. Your decision whether or not to participate will not affect your current or future relations with the University. If you decide to participate, you are free to withdraw at any time without affecting those relationships.

Contacts and Questions:
You may ask any questions you have now. If you have a question at a later time, please feel free to contact Sue Klappa at phone number: 651-690-8131 or email at klap0033@umn.edu. If you would like to talk to someone other than the researcher, please feel free to contact my advisor/professor, Dr. Jane Plihal, PhD at 612-624-3069 or Room 235 Peik Hall, 159 Pillsbury Drive SE, Minneapolis, MN 55455.

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher(s), you are encouraged to contact the Research Subjects' Advocate Line, D528 Mayo, 420 Delaware St. Southeast, Minneapolis, Minnesota 55455; telephone (612) 625-1650. The identifying number for this project is 0810E52101. **You will be given a copy of this form to keep for your records.**

Statement of Consent:
I have read the above information. I have asked questions and have received answers. I consent to participate in the study.

Signature:

____Date_________________
Participant

Signature of investigator or person gaining consent:

____Date_________________
Interviewer

Appendix C: Interview Guide*

Not-knowing what to do: Experiences of physical therapists "being stuck" during an ISL work.

Interview I:

- Think of a time during an international service-learning work when you experienced "being stuck" or "not knowing what to do." Tell me about that situation:
  - Where did it take place?
  - How long did it last?
  - How long did it seem to last?

- Imagine yourself in that moment: what was it like to be you?

Additional Prompts:

- I'm interested by what you just said. Can you tell me more about what you mean by "____?"
- That's a phrase I haven't heard you use yet. Can you tell me what that means?
- I want to make sure I understand you right. Can you give me an example?
- Do you recall what you meant . . . a time . . . etc?

Follow-up Interview Questions:

- What did you notice about my interpretation?
- How does my interpretation of your story fit or not fit your experience of being you in it?
- Should I change anything about my interpretation of your story? If so, what should I change?

*Questions are based on the dissertation work of Ben Anderson-Nathe (2005).

Appendix D: Overview of my Research Approach