In 2011, as part of my PhD, I conducted a study into crisis resolution home treatment (CRHT) using semi-structured interviews with service users and using an interpretative phenomenological approach (IPA). Being a novice researcher but an experienced mental health nurse, the challenge for me was to engage with participants in a caring way while maintaining objectivity and academic rigour. This article is a reflective account of my journey from novice to competent researcher, focusing on how the process of collecting and interpreting participants’ stories created role confusion and role overlap. In this article, she discusses the blurring of boundaries between clinical practice and research, and how to avoid this, preserve academic rigour and protect vulnerable research participants.


In this article...

- What are the challenges for the novice nurse researcher?
- What is reflexivity and how can it be used in the research process?
- Role confusion between ‘nurse’ and ‘researcher’ and how to avoid it

Talking points

A challenge for novice nurse researchers is to engage with participants in a caring way while maintaining objectivity

A nurse who is new to research may not yet have integrated the identity of a researcher

Using reflexivity in the research process can help spot role confusion and overlap

A research interview is a different process to a therapeutic interview

Nurse researchers need to be clear about their role and role boundaries with research participants

In 2011, as part of my PhD, I conducted a study into crisis resolution home treatment (CRHT) using semi-structured interviews with service users and using an interpretative phenomenological approach (IPA). Being a novice researcher but an experienced mental health nurse, the challenge for me was to engage with participants in a caring way while maintaining objectivity and academic rigour. This article is a reflective account of my journey from novice to competent researcher, focusing on how the process of collecting and interpreting participants’ stories created role confusion and role overlap. It aims to help aspiring nurse researchers by exploring the experience of being both a nurse and a researcher in the context of completing doctoral research.

CRHT should be a service based on a holistic model combining practical, social and psychological aspects of care (DH, 2001a). It is underpinned by a recovery model, with the values of the service user paramount in all interventions (DH, 2001b). CRHT is also grounded in a bio-psychosocial model of crisis acknowledging that there is a place for different treatments, including medications, and learning from and through crisis (DH, 2001a).

Research method and participants

My PhD research was qualitative and used an IPA. This involves “interpreting a lived experience” (Smith et al, 2009); in this case I was interpreting the lived experience of participants undergoing CRHT.
of service users experiencing a mental health crisis who received support in the form of CRHT.

Ten participants were selected for the study using broad eligibility criteria – they had to be aged between 16 and 65 and have used CRHT in the previous three years. I conducted semi-structured interviews in which participants told their stories of mental health crisis and CRHT support. These stories were not just a recollection of their time receiving CRHT, but often told of crisis being embedded in their lives.

**Blurring of boundaries**

Ideas of British sociologist Ann Oakley (born 1944) had influenced my early thoughts on my place as researcher, armed with my professional skill set and attitudes. Oakley had clear views on the relationship, in feminist research, between researcher and participant, and thought that a key role of the researcher was to develop relationships with participants – in her case, these relationships developed over a long period of time (Oakley cited in Roberts, 1981). She was thereby challenging the consensus in the 1970s that scientific objectivity and detachment were paramount. When I undertook my research, I had extensive nursing experience, and I too developed relationships with participants during the short time I spent with them. This led to a blurring of role boundaries.

**Reflection and reflexivity**

Throughout the research process, I adopted a reflective and reflexive position. This is how I practised as a nurse and it seemed a natural way to approach research. As I went along, I reflected on the way I was performing and on the way participants were engaging.

As a nurse, I believed service users feel much more valued if they are encouraged to tell their own stories, as these help us understand what they are experiencing in a more holistic way. When I undertook my research, I had extensive nursing experience, and I too developed relationships with participants during the short time I spent with them. This led to a blurring of role boundaries.

**Box 1. Vignettes**

**Vignette 1. Eleanor and Rob**

“Eleanor was supported at interview by her husband Rob. At one point Rob blamed his own poor health on the fact that he had to support her. He appeared to become exasperated with her, saying that he had become ill as a result of having to look after her. This was expressed as ‘annoyance’ and was not something I had anticipated. I had a choice to either let this disagreement run its natural course or try to avert it. As a researcher, letting the disagreement run its course would potentially take me away from the focus of my research; as a nurse I may have seen the discussion as therapeutic. I chose to introduce a diversion. They seemed to become more relaxed as a result of this.”

**Vignette 2. Denise**

“Denise told me that she was unhappy with the support she was getting from the CRHT team. She thought that they were approaching her condition in the wrong way. She knew I was a nurse and asked me to tell the team how they should carry out their interventions. I had to remind her that I was there as a researcher therefore my role was as an academic.”

**Vignette 3. Eleanor**

“Eleanor asked if I could change how services worked. I responded that I could not. Again I explained I was an academic but I hoped that my work would be read or used in training, for services to learn from the participants.”

**Vignette 4. Cat**

“Cat told me that her daughter had been taken away due to her suicide attempts. I felt trusted with this disclosure. However, it could be argued that participants felt coerced into disclosure. Cat might have seen me as a nurse and therefore revealed more than she might have done had I ‘just’ been a researcher.”

**Vignette 5. Harry**

“Harry had perhaps felt he did not have to explain what it was like having depression, because he thought I would know that being a nurse; which was a lesson for me in terms of the power I possessed in this role; something I was uncomfortable with. Had I actually unwittingly demonstrated my clinical knowledge of his situation, and had we moved into a therapeutic encounter would that have placed me, in his eyes, as part of the care team and not as an independent academic researcher?”
Clinical Practice

Discussion

researchers need to be aware of the risk of becoming a ‘research instrument’. While I initially believed I was acting in an objective manner, on reflection, it became apparent that I was influencing participants because of who I was and that they, in turn, were influencing me.

A second definition of reflexivity is offered by Stanley (1993), who describes it as “treating one’s self as subject for intellectual enquiry”. Similarly, Finlay and Gough (2003) describe the need for researchers to have “a critical (and embodied) self-awareness of their own (inter-)subjectivity, processes, assumptions and interests” and to examine ‘how our attitudes/values/behaviour impact on the research process and findings”. On reflection, I became aware that my own attitudes and behaviours were often those of a mental health nurse.

A third definition of reflexivity, offered again by Wetherell (2001b), is that one must “acknowledge the theories, values and politics which guide the research”. The theories and values that appeared to be clouding my research were those underpinning my professional status and practice as a nurse.

Role confusion

Originally, I believed that my professional training as a nurse would provide useful tools for a sensitive researcher. I thought these tools would be an advantage, and I made that claim when I orally defended my thesis in front of a panel of examiners. However, the panel challenged my claim, suggesting that there had been some role confusion and overlap, and arguing that I had behaved as a nurse at several points in the process. To illustrate their point, the panel picked up a vignette that was included in my thesis (vignette 1).

In the interview with Eleanor and Rob (vignette 1), my decision to introduce a diversion in the discussion had been made in the moment. The decision on whether the interview was proving problematic or cathartic was a nursing decision. Such decisions about people’s mental state are the norm for a mental health nurse. In the same situation, a non-nurse researcher may have made a different decision.

Empathic interviewing

The nursing skills I brought to the research included using open-ended questions showing congruence, genuineness and empathy with participants’ situations. I was interested in them and their story. I was comfortable with giving them space and time to consider their answers. I asked participants to tell me their story in their words and just prompted responses.

Leslie and McAllister (2002) discuss how, in research, “nursedness” can lead to intimacy and disclosure, and I recognise this in the responses from some participants. These nursing skills may have been helpful, but they also possibly led to confusion for participants and myself.

Several participants said that they felt better for telling me their story. They seemed to imply that the interview had been cathartic. It is likely that, as a nurse, my performance in the interview would have been conducive to a therapeutic interaction, so the interview process could be seen as having a therapeutic dimension. A non-nurse researcher would possibly not have achieved similar outcomes.

"I was producing a piece of work called ‘research’, but my identity had not had time to change"

Misplaced expectations

Some participants appeared to perceive me as a nurse, which in turn affected the interviews. Vignettes 2, 3, 4 and 5 show reflections I wrote in my diary after the interviews with Denise, Eleanor, Cat and Harry.

On reflection, I wondered whether my response during the interview with Eleanor (vignette 3) had been inadequate, and whether Eleanor would have agreed to see me if she had been aware that I could not influence the services she was using. She might have agreed to participate in the research for the wrong reasons. Regarding the interview with Harry (vignette 5), I later reflected on the fact that I may have unconsciously ‘led’ him to respond as a patient, not a research participant.

These vignettes reveal that:
- sometimes reacted as a nurse rather than a researcher;
- participants saw me as a nurse, even when I was trying to act primarily as a researcher.

As a result, some participants wanted support in their ongoing care and also revealed more than they might otherwise have done. They may have agreed to be involved because of misplaced expectations.

Forming a new identity

Stern and Bruschweiler-Stern (1992) make the following observation about becoming a mother: “In a sense, a mother has to be born psychologically, much as her baby is born physically. What a woman gives birth to in her mind is not a new human being but a new identity: the sense of being a mother.”

I am both a nurse and a researcher. At the start of my research, I was a mental health nurse with 20 years’ experience but a novice researcher. I was producing a piece of work called ‘research’, but my identity had not had time to change. My existing identity was that of a nurse, and the process of carrying out the research was leading me to form a new psychological identity – that of a researcher.

As I had not yet internalised my new role of researcher at the time of the research, it is perhaps unsurprising that I reverted to the role that I had long internalised – the mental health nurse. One year after completing my PhD, I still do not feel that I have fully internalised the new role.
Experiencing the world
Heidegger’s thoughts, as interpreted by Dreyfuss, helped me make sense of the situation. Heidegger suggests that there are three main ways of experiencing the world: ready-to-hand, unready-to-hand and present-at-hand (Dreyfuss, 1991). He argues that, when an action we are performing is disturbed because the tool we are using to perform it no longer works, the tool becomes unready-to-hand. A tool becomes present-at-hand when we become conscious of it and focus on it, rather than on the action we are performing.

At the time of the research, my ‘ready-to-hand’ skill set was that of nurse, but my present-at-hand skill set was that of researcher. Because I was an expert nurse, the tools of nursing were ready-to-hand for me to use without me thinking about them. They had become transparent to me and I was not aware that I was using them, as I was focused on the task at hand.

When Eleanor and Rob started arguing during the interview, I became aware that this was not useful for the research. It could be argued that, at that point, my researcher skill set had become unready-to-hand. This disturbance led me to reverting to my ready-to-hand nurse skill set. This happened in two ways: first, I responded to their mounting emotion and second I introduced a diversion; both these reactions are essential skills of mental health nurses.

“It became clear that participants had not always taken these messages on board”

Participants may have perceived me as a nurse. If so, their ready-to-hand way of engaging with me might have been as a patient. They had been a patient before, possibly many times, and had interacted with someone who behaved like me—like a health professional. If they had never been interviewed by a researcher before, it is possible that their way of engaging as a research participant was unready-to-hand. This may have led to unintentional over-disclosure, as well as participants seeing me as having powers they did not have.

Clearer explanations
In the future, I would try to be clearer when explaining the roles of nurse and researcher to vulnerable research participants. At the time of the research, I thought that I had dealt with that issue. The covering letter clearly stated the voluntary nature of the research and explained my role in the process, and the pre-interview felt sufficient. On reflection, however, it became clear that participants had not always taken these messages on board. My reflection post-research has led to retrospective concern on my part that participants may have felt confused and let down.

Therapeutic or research interview? There is a difference between a therapeutic interview and a research interview. Kvale (1996) states: “Both may lead to increased understanding and change, but with the emphasis on personal change in a therapeutic interview and on intellectual understanding in a research interview”.

As a result of my reflection, I can now articulate the distinction between a research and a therapeutic interview, but it would have been helpful to have had this understanding before carrying out the interviews.

Conclusions
I started my PhD believing that my nursing skills would be an asset for conducting narrative-based research with mental health service users. A reliance on an ingrained identity and well-established skills led to a blurring of boundaries, role confusion and role overlap. My own confusion may have left participants feeling confused too.

Reflecting on my experience has helped me develop as a researcher and better understand the role of the nurse. Learning to differentiate between the two roles was a crucial element of the process. I have also learnt that you need to detach yourself from your professional background, and that it is best to address such issues at ethical approval stage, with a clear plan of supervision.

When I come to supervise PhD students, I will ensure that they are prepared for such problems and that they have researcher behaviours and skills ready-at-hand for their interviews.

Further recommendations for novice nurse researchers feature in Box 2.

Recommendations for novice nurse researchers

- Develop self-awareness
- Understand the difference between being a nurse and being a researcher
- Recognise the positive aspects you bring to research as a nurse
- Decide at the start what kind of relationship you want to develop with participants
- Be clear with participants about your role (you are a researcher) and who you work for
- Check before each interview that the participant understands your role and its boundaries
- Conduct research interviews, not therapeutic interviews
- Avoid being drawn into a nursing role
- Reflect as you go, keeping a reflective diary
- Discuss boundary issues and how you will react to different scenarios with your supervisor

References

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