

From Clinician to Researcher: The Challenges and Rewards

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After many enjoyable years of practice, I made a decision to retire, and felt the need for new but related interests. I knew it was going to be research because I have long considered the progress of my clinical work from that aspect. As a student, I had been trained in quantitative method, and I expected to experience a culture shock when 'permitted' to relax my previous research mode, with its dependence on statistical approaches based on preemptive hypotheses, to undertake a qualitative methodology novel to me.

I chose to research 'The Experiences and Perceptions of Mothers of Boys with Attention Deficit Hyperactivity Disorder' for three main reasons. One was my long-held interest in family therapy for chronic behaviour problems in primary school-aged children. The behaviours associated with ADHD are fairly 'visible', you might say, in that context. Next, I chose boys because they attract the diagnosis in a ratio of 3:1 compared with girls. The third reason, since I am a neuropsychologist as well as a clinical psychologist, was my interest in the presumed neuropsychological aspect of the condition.

Research is continually referring back to the similarity between the behavioural symptoms of ADHD and those associated with known and established prefrontal lobe insult (Barkley, 1997; and many others). These behaviours include a limited capacity for forethought, a lack of empathy, an inability to sustain motivation, and a greater than normal degree of field dependency (Barkley, 1998). Thus far neuroimaging has failed to identify consistent matches between underlying cerebral dysfunction and ADHD related behaviour, although several studies have shown anomalies in cerebral structure involving the prefrontal lobes.

These behaviours attract widespread disapproval and rejection in many social and educational contexts (Barkley, 1997). A differential diagnosis is, I believe, necessary for many reasons, not the least of which is recognition of ADHD as a genuine disability. In recent years, it has been increasingly recognised that deficits in behavioural inhibition are the characteristic of ADHD which most distinguishes it from other mental and developmental disorders (Pennington & Ozonoff, 1996, and others). Despite these tentative insights, the establishment of anything more

than a provisional diagnosis of ADHD in these children is still often out of reach.

Friends and colleagues, and other researchers in health and medicine were beginning to talk about qualitative methodology. I became interested and decided to do some training in qualitative methods, because this paradigm was not part of my psychology training. The first hurdle I encountered was associated with the traditional qualitative research model, which I initially adopted. When I began the research, I thought that this was the only qualitative method available. I wanted to conduct a short pilot study, prior to embarking on a Ph.D.

The traditional qualitative model was far from compatible with my natural preference. Oakley describes it as follows:

The interviewing situation is one in which the interviewer elicits and receives, but does not give information ... interviewers ... adopt an attitude towards interviewees which allocates the latter a narrow and objectified function as data ... interviews are seen as having no personal meaning in terms of social interaction, so that their meaning tends to be confined to their statistical comparability with other interviews and data obtained from them (1981: 30).

I had other difficulties trying to come to terms with the traditional model. For instance, I was enjoined by its particular structure to refrain from all but the briefest questions for clarification, and also prohibited from recording observations of nonverbal behaviour. Above all, I understood that I must not interpret *anything*. My interviewing skills seemed almost completely irrelevant in this situation.

It was at that point that my supervisor suggested I read the feminist literature on the subject and then a whole new world of excitement opened up. The feminist model made a lot of sense to me. I changed my method at that point in order to take it up. It is similar to my approach in clinical



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work, in the sense that it takes the form of a conversation between people who share a common interest in the topic under discussion. This notion is supported by Richardson (1994), who believes that in order to establish rapport and trust, the practitioner must be careful to balance between professionalism and friendliness. The postmodern feminist approach seeks to understand the meanings and understandings of the respondents in relation to the research topic.

As soon as I began reading this literature and realised that it was appropriate for me to conduct the interviews in a conversational way, the problem disappeared. More joy was to follow when it was clear that the recording of emotions (nonverbal observations) was compatible with the concept of empiricism. In fact, it was no longer inappropriate, as I had understood it to be, to record whatever I chose in addition to the participants' verbal responses. Whatever I observed was valid data.

The interpretations I made when categorising the data were subjected to the usual tests of validity, that is, consultation with team members, reference to the literature, and my own self-monitoring. From the outset, I had been concerned about the influence of my own subjectivity in data selection and interpretation. Before reading the feminist literature, I had felt safe with the strategy of triangulation (Willms & Johnson, 1993, and others) as a measure to reduce this risk. Triangulation is:

... a strategy for ensuring a study's findings are not the artefact of a single method, a single source, or a single investigator's biases. It is, therefore, a means of increasing confidence in the validity or authenticity of the data and its interpretation (Willms & Johnson, 1993: 6).

Further reading, however, led me to consider Richardson's (1994) metaphor of 'crystallisation' as offering a richer source of interpretable data. Richardson describes a crystal's

... symmetry and substance with an infinite variety of shapes, substances, transmutations, multidimensionalities, and angles of approach. Crystals grow, change, and alter, but are not amorphous (522).

Richardson's rationale for this metaphor convinced me to opt for 'crystallisation' over 'triangulation' for the simple reason that it permits limitless possibilities for the selection and interpretation of data beyond those suggested by a flat, two-dimensional triangle. I found this approach both exciting and a bit scary. It was exciting because of the freedom to speculate which it offered, but scary because I felt obliged on the basis of this metaphor to identify all possibilities, and I was nervous in case I missed something I should have seen. But of course I do not have to identify *all* possibilities — otherwise interpretation would become a 'never-ending story'. I decided that I should simply identify the most significant items out of the transcripts of the interviews, that is, those most relevant to the research question.

My nervousness about the influence of my own subjectivity on the interpretations I might make was no longer

the nagging problem it had been. By following my clinical method of checking my own ideas with my interviewee(s), as well as using the methods mentioned above, the issue of a subjective bias would be reduced. Even so, with respect to subjectivity I struggled for some time. Initial reading of the literature (e.g. Borman, Le Compte & Goetz, 1986) had led me to believe that subjectivity was a bugbear to be avoided as one would a virulent virus. Indeed, initially I tried to conduct the research interviews in a way that might promote that goal. But I was uneasy because I felt like a less-than-competent robot, a robot that required fine-tuning to block subjectivity. I quickly lapsed into revealing my subjective responses nonverbally. I felt guilty because no doubt my unspoken responses arose out of my subjective self, but I just could not be the robot I honestly thought I had to be.

I had another worry, though, and that was my concern lest the participants' own subjectivity influence their interpretation of the relevant events in their lives. 'How will I know they are telling the truth?' I look back on such naivety with a blush. There can be no doubt that it arose out of my early conviction that quantitative methods established 'truth', because they had the numbers to support the interpretation. Reading Patton (2002) disabused me of that belief. He believes that there is subjectivity in all research enquiry, justifying this belief on the grounds that researchers choose the research question, the method, the analysis, and the interpretations of the data. More importantly, I finally allowed myself to shift from the belief that 'correct' results were what I should aim for. I was able to move on to the knowledge that in qualitative research my job was to understand the viewpoint of the interviewees, to share the meanings of their experiences with them.

Interviewing Similarities between Clinical Psychology and Qualitative Research

There are helpful similarities between certain aspects of the way I interview clients in clinical consultations and the in-depth interviewing style used in qualitative data collection. One similarity is attentive listening. The other is the development of hypotheses from information gathered during interview, as distinct from the formulation of premeditated hypotheses such as are relied on in quantitative research. Just as in my clinical interviewing, I develop hypotheses selectively and progressively during the interview process, selecting information as I receive it, with reference only to its relevance to a previously prepared guide (the topic guide), and to information which connected, positively or negatively, with information already received. Another similarity to my way of interviewing clinically is that I am thinking systemically, which leads to the types of guiding probes and open-ended questions I am prompted to offer both during clinical consultation and qualitative interviewing. In that way the clinical consult, like the qualitative interview, also becomes a conversation, albeit of a specific kind.

This and discussion of the issue with my supervisor was my initial encouragement to structure the interview as a

'conversation' between the interviewee(s) and myself, albeit a conversation of a specialised type. The conversation should ideally be constructed to elicit the information I needed in order to answer my research question, at the same time, allowing me to be 'present' at the interview without dominating it¹ (Oakley, 1981: 33) — a conversational style very similar to my clinical interviewing style. I felt much more comfortable when I approached interviews in this way, partly because it was familiar to me. Furthermore, the mood of the interviews changed. I noticed the increased warmth in the interchanges between the respondents and myself.

These changes then caused me to look afresh at the risk of my own subjectivity influencing the collection and interpretation of the data. I knew I had to monitor myself against any unconscious lapse into a mood more appropriately suited to a chat over a cup of coffee.

The problem of limiting any undue influence of subjectivity was probably the most challenging practical difference I encountered when I began qualitative research. This was not because subjectivity is a nonissue in clinical work, since it is equally important to avoiding succumbing to it there. But in that situation there are also techniques that I am familiar with to protect against too much subjectivity. Rather, the challenge was due to the fact that I still had not fully absorbed the notion that in qualitative research the aim lay not in seeking 'facts' or 'truth', but gaining an understanding of my respondents' views and beliefs.

Another challenging difference was the need to avoid intervening (i.e. offer counselling ideas). Based on my developing hypotheses and my clinical experience, I could have discussed ideas for the resolution of at least some of my interviewees' problems. Indeed, I might have done that except that none of them asked me for any help. What I did instead was to use occasional open-ended probes aimed at obtaining clarification of the story the interviewee was offering.

For example, I said to one mother, 'You spoke earlier of his embarrassing behaviour in public. Could you talk a bit more about that?' In that case, as in other examples arising during data collection, the comment by the mother was made in passing, and I considered it important for her to elaborate on it as part of the 'how', 'where' 'why'² 'what' and 'when' aspect of the interview that I was accustomed to using as part of systemic enquiry (Sanders & Robinson, 1985).

The most difficult hurdle when I look back on my research journey was dealing with the analysis of the material I had collected. I found it more painstaking than the process I was used to when I was dealing with quantitative data. In that paradigm, where biochemical data, for instance, are electronically measured, there is no real danger of losing data due to the inability of the computer to think outside the boundaries it has been set by the program. In qualitative analysis, too, the data can be analysed electronically, and there are software packages for this. However, the danger of losing subtle details in the informants' stories, and of being unable to read between the lines, is very real. These may be lost simply by not reporting the informants'

affect, her sadness or her gladness, as she tells her story. In any case, the data to be fed into the program has to be selected by the researcher before computer analysis, and the computer will act only on the data available. I felt more satisfied approaching qualitative data analysis by hand coding, and using a paper based codebook and theme matrix.

Conclusion

From both my professional and personal experience, I found that data obtained using the qualitative method was more capable of answering my research question than the quantitative method, although I believe I may well be using quantitative analytic procedures in a complementary fashion in the future. Let me explain. The qualitative enquiry allows for more comprehensive information to be available, not only because it allows for both verbal and non-verbal data collection, but also because the participants are encouraged to elaborate on their experiences, as distinct from, say completing a questionnaire. It permits a fuller grasp of the participants' experiences and understandings of the events in their lives which are under question than is possible if using a strictly 'experimental' approach. Quantitative analysis might then follow an initial thematic analysis, but it is not the first step.

Well, there it is — my journey. Although I started with some trepidation, having done no research for many years, I have experienced great rewards in this endeavour. I was working, from a research angle, with a particular aspect of family therapy of absorbing interest to me; that is families troubled by chronic behavioural problems in their children. I believe the transition from clinician to researcher is easier than it may be for researchers in other paradigms, because of the awareness of the different interviewing styles available. On the one hand, the positivist style seeks only facts and causes, and also avoids giving any feedback to the respondent out of concern that the interviewee may be led to respond in a certain way. On the other hand, a conversation such as the feminist method of qualitative research is sufficiently flexible to allow more complete information to become available.

It almost seems like a dream now, my initiation into this research methodology. I expected to have to make radical changes in the way I thought about this project. Given that my previous research experience had been experimental, there were indeed some dramatic changes in procedure but the struggles I anticipated in changing my thinking from qualitative to quantitative research models were, in the event, not so challenging as I expected. My position vis-à-vis the participants was very similar to the one I habitually adopted in clinical consults. In both situations I was not necessarily seeking truth. Rather, I was trying to identify behavioural patterns, interactional relationships, and personal beliefs and experiences. My ultimate aim there was to unlock the rigid interactional patterns that held families in miserable thrall. That was achievable only by attentive listening in an atmosphere of rapport and trust such as I have

experienced in interviews with research participants. Mutual respect is part of this atmosphere. It is mutual respect that creates an atmosphere which is antipathetic to judgmentalism. So in the sense that I was in familiar professional territory, the transition was seamless.

So it was with the abandonment of preemptive hypothesising. Initially, because my mind-set was stuck on comparing quantitative method with qualitative method, I wondered how I would approach my research question without a preemptive hypothesis. The realisation that this would be very similar to the way I approached clinical questions suddenly made sense of it.


I now feel comfortable with the qualitative method I have used, and undoubtedly will continue to use, in psychosociological areas. I look forward to embarking on further research employing a combination of qualitative and quantitative methods.

Endnotes

1. It is recognised that this is not always easy to establish given that the professional is perceived in some seen to be the 'expert'. Some ways of reducing its influence is to conduct the interviews in a situation where the interviewee feels most comfortable, and at a time most convenient. That is, the interviewee is the decision maker in that context. Another way is for the interviewer to be another human being, not an expert.
2. With reference to 'why', as a student clinician I was advised by some supervisors not to ask that, in particular I believe because it may come across as accusatory.

Indeed it may, but one way it can be asked, without fear of offence is, for example, 'Why do you think that is?' in tones of polite curiosity.

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