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Lessons Learnt by an Experienced Clinician-Novice Researcher Throughout the Process of Qualitative Research Interviewing

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Abstract

Within occupational therapy, the complex process of transitioning from clinician to clinician-researcher often presents challenges demanding critical contemplation. Methodological issues and ethical challenges can arise throughout the emergent transition into role duality, potentially impacting upon novice clinician-researcher development, influencing research processes and quality. As part of the Task-AT Home qualitative study, a reflexive critique of interview processes, guided by the reflection-on-action rubric and a typology of catalysts for dual-role experiences was conducted. The reflective critique identified commonalities and differences between clinical and research interviewing. Additionally, through three exemplars of experience, the critique provided insights into how clinical reasoning processes were used during interviews, influencing qualitative research processes. Having explored what can happen when an experienced clinician utilises clinical reasoning skills within a qualitative research project, skills and strategies have been identified, aiming to inform and support occupational therapists transitioning from clinician to clinician-researcher. Acknowledging the sometimes-imperfect realities of engaging in qualitative research, made visible by practicing reflection on action and sharing messy examples or occasions of personal conflict, can provide instructive moments for future clinicians looking to make the transition from clinician to clinician-researcher.

Keywords

clinician-researcher, occupational therapy, qualitative interview, reflexivity, research ethics

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Within occupational therapy, the complex process of transitioning from clinician to clinician-researcher often presents challenges demanding critical contemplation. Methodological issues and ethical challenges can arise throughout the emergent transition into role duality, potentially impacting upon novice clinician-researcher development, influencing research processes and quality. As part of the Task-AT Home qualitative study, a reflexive critique of interview processes, guided by the reflection-on-action rubric and a typology of catalysts for dual-role experiences was conducted. The reflective critique identified commonalities and differences between clinical and research interviewing. Additionally, through three exemplars of experience, the critique provided insights into how clinical reasoning processes were used during interviews, influencing qualitative research processes. Having explored what can happen when an experienced clinician utilises clinical reasoning skills within a qualitative research project, skills and strategies have been identified, aiming to inform and support occupational therapists transitioning from clinician to clinician-researcher. Acknowledging the sometimes-imperfect realities of engaging in qualitative research, made visible by practicing reflection on action and sharing messy examples or occasions of personal conflict, can provide instructive moments for future clinicians looking to make the transition from clinician to clinician-researcher.

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Introduction

For occupational therapists, transitioning from clinician to clinician-researcher is a journey involving a distinct role change, actively driven by a personal predisposition for and a determination to participate in high quality research (Cusick, 2001). Before transitioning, the occupational therapist has firstly identified as a clinician. As such, they are grounded in the philosophies, values, and theoretical frameworks within which their professional practice experience has evolved. The role of clinician-researcher further expands their professional repertoire, requiring the occupational therapist to continue to provide direct therapy services while also conducting research (Yanos & Ziedonis, 2006).

Whilst not required to shed their "clinical skin" when undertaking research, clinician-researchers often use their clinical reasoning skills throughout the research process that may at times predispose them to ethical and methodological challenges such as conflicting expectations, orientations, or competing obligations (Hay-Smith et al., 2016, p. 12). Investigations into the transitionary process of role making and a reflection on how role duality may impact upon the methodological processes and ethical considerations inherent in qualitative research from an occupational therapy perspective is limited. Of those studies

found, the focus has been on examining the general experiences of clinicians actively involved in research (Cusick, 2000); exploring the influence of researcher-respondent relationships, power, and the importance of reflexivity (Conneeley, 2002); as well as investigating the emerging process involved in "becoming" a clinician-researcher (Young, 2004).

Acknowledging and accounting for experiences is a reflexive practice that is considered both an important process within the occupational therapy profession and an essential part of qualitative research (Liamputtong, 2020; Schell & Schell, 2018). An understanding of the potential challenges that may present during role transition from clinician to the dual role of clinician-researcher can provide educative opportunities for clinicians also looking to make a similar transition. Raising awareness of the challenges that may be experienced by occupational therapists starting out on their research journey, particularly during the data generation phase, can look to inform and aide understanding of possible ethical dilemmas and methodological risks associated with an emerging dual role. Examining experience allows not only for the identification of possible dual role challenges but is also necessary for continuous development of effective support structures and practices, enabling quality research processes and outcomes in all aspects of qualitative research, particularly for the novice researcher.

Reflexive critiques of a clinician's role working in the qualitative research space can be supported by the application of useful tools designed to support the process of reflection. Frameworks have been developed to support critical contemplation of the practices and processes involved when undertaking qualitative research. One such example is the "Reflection-on-Action" rubric (Stynes et al., 2018), which guides emerging researchers through a reflective process by encouraging consideration of broad issues relating to topic and literature, as well as personal contemplation of issues that may arise throughout a project, including the research experience itself. Through application of the rubric, qualitative researchers are encouraged to question themselves and how they may influence the research process. This reflective process supports critical contemplation of the potential challenges associated with a clinician transitioning into the emergent role of novice clinician-researcher.

Additionally, in an effort to assist clinician-researchers to plan and conduct methodologically and ethically judicious research, Hay-Smith et al (2016) devised a typology of common catalysts of dual-role experiences. Their framework was constructed following a systematic review and synthesis of 36 qualitative and quantitative reports of dual-role experiences within the health professions, including one study conducted by an occupational therapist (Hay-Smith et al., 2016). This typology is a useful tool to further inform reflective practice by clinician-researchers, as it encourages consideration of the interactional influences of action and behaviour upon the qualitative research process, with a particular focus on relationships with study participants.

Complementing the "Reflection on Action" rubric, aspects of the dual-role experience framework have been used within this single participant case study as a lens through which to explore and describe my own experiences as a seasoned occupational therapist, transitioning for the first time into the unfamiliar role of clinician-researcher, with a specific focus on the process of data generation within a qualitative research project.

By undertaking this reflexive critique, I aimed to:

1) Consider and share what happened when an experienced clinician used their clinical reasoning skills during the research process whilst transitioning to clinician-researcher.
2) Identify what skills and strategies occupational therapists need to support their transition from clinician to clinician-researcher, particularly during the data generation phase of qualitative research interviewing.

Setting the Scene

Professionally, as first author, I am an occupational therapist with 24 years of clinical experience working in hospital and community settings. For the past eleven years I have worked on the acute stroke unit in a regional hospital in NSW, Australia. Working within a multi-disciplinary team, I support and enable the occupations of people after stroke, as well as providing education and assistance to their caregivers and families. Since 2019 I have also worked in various capacities as a lecturer at our local university campus, teaching into the first, second, and third-year occupational therapy degree programmes. My recent experience within academia stimulated an interest in research methods, process, and design, and when a research opportunity was advertised amongst our regional therapy network, I made enquiries and subsequently applied. To my delight, I was selected as the successful applicant. I am currently enrolled in a Higher Degree Research (HDR) program as a full time PhD candidate and with the support of the local health district, I am maintaining my clinical role as an occupational therapist on the acute stroke unit at our local hospital eight hours per week.

The HDR project I am conducting is a qualitative study embedded within a randomised controlled trial (RCT) known as "Task-AT Home," which is investigating whether a particular type of upper limb intervention (task-specific training) conducted in the home is more effective than usual care in improving arm and hand function following stroke. My primary supervisor, Dr Meredith Tavener, is an experienced health researcher with 20+ years of experience teaching and practising qualitative research methods, and Task-AT Home trial manager. Paulette van Vliet is a professor of physiotherapy and chief investigator of the Task-AT Home trial, supporting my PhD candidacy as secondary supervisor. Ethical approval has been granted for this project by the Hunter New England Health Research Ethics Committee (HNEHREC Reference No: 18/03/21/4.04), and the NSW Health Research Ethics Committee (NSW HREC Reference No: HREC/18/HNE/69).

Where the focus of the Task-AT Home RCT was to measure the effectiveness of the therapy program using standardised assessments, the purpose of the embedded qualitative study was to explore participant understandings of how change following stroke occurred; how change was perceived; and what that meant to participating stroke survivors, caregivers, and therapists. The qualitative study was also designed to contribute explanatory information about why participatory experience in the therapy program may be congruent (or incongruent) with the quantitative results. Data gathering involved conducting two in-depth, semi-structured interviews with each consenting stroke survivor who received the task-specific intervention through the RCT, as well as their caregivers and therapists involved. A total of 15 participants were recruited into the qualitative study, consisting of eight stroke survivors (five female, three male), three caregivers (two female, one male), and four female therapists (three physiotherapists and one occupational therapist). Some stroke survivors interviewed as part of this study had experienced mild cognitive, speech, and language deficits following stroke. As such, during interviews I employed strategies commonly used with people with aphasia to support storytelling. I assisted narrative expression by encouraging figurative language and provided extra time to ensure stories were satisfactorily relived and retold. Pauses and silences were respected, allowing reflective moments and thoughts to be gathered. Whilst remaining attentive and practicing focussed listening throughout, I built a platform upon which I could use exploratory, probing questions, advancing a detailed diversity of experienced meaning within each interview.

Interviews took place between March of 2020 and February of 2022, and dependent upon COVID-19-mandated restrictions and participant preference, were conducted either in person or via telephone. The first interviews were scheduled immediately after therapy participation and a second interview occurred six months later, providing a longitudinal aspect

to the study that temporally aligned with quantitative data collection. The intention of the first interview was to explore perspectives around initial experiences of participation and a second interview with each participating stroke survivor, caregiver, and therapist was designed to capture new and enduring narratives constructed through the passage of time.

Guiding my selection of methods and analytic process in the qualitative aspect of the Task-At Home study is the methodological approach of a narrative inquiry. In a narrative inquiry, stories are viewed as the means through which people express the lives they live, revealing ways in which they understand and make meaning from momentary and accumulative experiences (Josselson, 2011). Health and health care are not only entrenched in narratives, but can be enriched by them through foregrounding stories of illness and recovery experiences (Bleakley, 2005). Narrative inquiry is an approach that has previously been used in qualitative health research, as it allows for the exploration of personal and in depth accounts of change, adaptation and life challenges (Sharp et al., 2019). During data generation, a narrative inquiry is often reliant on in-depth interviews that use open ended questions, providing interviewees with narrative opportunities that invoke a detailed account of the phenomena under study (Riessman, 2008).

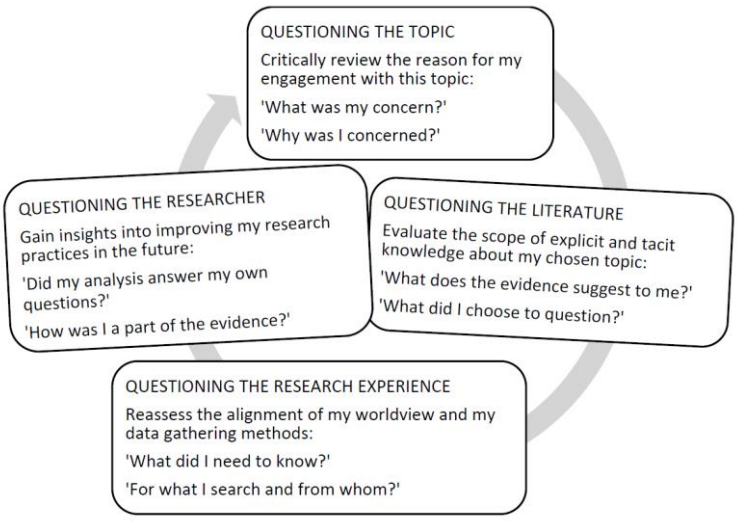
One of the reasons I was entrusted with this study was my extensive experience participating in interviews with stroke survivors and their families, within a variety of hospital, home, and community settings. Over many years working as an occupational therapist, I have conducted thousands of clinical interviews, allowing for the continual development of essential interviewing skills. With time and dedicated practice, important skills such as active listening, building and sustaining rapport, negotiating sensitive subjects, and managing potentially conflicting encounters have evolved and gradually matured. I was aware that these skills would be useful in the context of a research interview; however, before starting the act of data gathering, I knew I needed to reflect on how a research interview may differ to a clinical interview. It was likely that I would need to make a transition. What would such a transition involve and how could this adaptation be assisted? I knew I needed to prepare.

Methods

This reflexive critique, which focusses on data generation through qualitative interviewing, was initially informed by use of the Reflection-on-Action rubric (Figure 1; Stynes et al., 2018).

Figure 1

Reflection-on-Action rubric © (Stynes et al., 2018) used under CC BY-ND 4.0



I was introduced to this framework by my primary PhD supervisor (Dr Meredith Tavener). Being a novice researcher, it proved to be a useful and practical tool, as the rubric incorporates prompts that encourage reflection within and throughout each stage of the research project. By questioning the topic, the literature, the research experience, and my own influence on the project in an iterative manner before, during, and after each stage, I was able to consciously observe and consider my own positionality within the research process. This method of constant, focussed questioning proved particularly valuable during the data gathering phase, enabling consideration of interview purpose, as well as providing a tool to reflexively evaluate my own performance before, during, and after each interview in relation to the research question.

Journaling (the practice of keeping a research diary) is a well-established means through which qualitative researchers record reflections about the process and progress of their research (Braun & Clarke, 2013). With this understanding, I kept a journal that contained my observations, feelings, and curiosities throughout my research journey. Maintaining a journal provided a functional means through which to critically appraise the research topic, relevant literature, the research experience, and my own influence upon the research as it continued to unfold. Journaling not only provided opportunity to reflect on experiences before and during each phase of the research project, but also a platform from which I could undertake a critical contemplation of the processes I had undertaken after they had occurred. As part of my transition into the emerging researcher role and in an effort to continually learn from my experience, I regularly reviewed my research journal entries. This reflexive critique contains extracts from my journaling specific to occasions pertaining to before, during, or after a qualitative interview.

To support a systematic approach to this reflexive critique and provide a means to help organise the journal entries, I considered each occasion in relation to the existing typology of common catalysts of dual-role experiences, as devised by Hay-Smith et al (2016). Hay-Smith et al (2016) describe two overarching catalysts that influence the dual-role experiences of clinician-researchers: "Clinical Patterns" and "Connection" (Hay-Smith et al., 2016, p. 3). "Clinical Patterns" involve the clinician-researcher acting as a "clinical resource," where they use their clinical skills or reasoning during the research interview. Hay-Smith et al (2016) identify five themes as to how this may occur: (1) Clinical queries; (2) Perceived Agenda; (3) Helping Hands; (4) Research or Therapy; and (5) Uninvited Clinical Expert. The second of Hay-Smith's catalysts, "Connection," describes a bond between the clinician-researcher and the participant that may have formed as the result of a shared experience of the clinical context, thereby potentially influencing suppositions, and actions. Hay-Smith et al (2016) describe five themes that comprise this overarching catalyst, which include: (6) Clinical Assumptions; (7) Suspicion and Holding Back; (8) Revelations; (9) Over-identification; and (10) Manipulation.

Through a process of aligning interview occasions identified through journal review, alongside catalysts that influence dual-role experience, I was able to further explore and critically contemplate what happened when I used my clinical reasoning skills throughout the data generation process. Following this contemplation, I then considered more broadly what types of skills and strategies occupational therapists would require to support a successful transition from clinician to clinician-researcher.

Findings and Discussion

My critical contemplation, guided by the Reflection-on-Action rubric and the typology of common catalysts of dual-role experiences, resulted in a comparative reflection of the commonalities and differences between clinical and research interviewing, as well as a consideration of the influence of clinical reasoning processes blending with a research mindset

within a research interview context. The following is a description of my findings, interlaced with a contemplative discussion regarding invaluable lessons learnt throughout the qualitative interviewing process.

Commonalities and Differences Between Clinical Interviews and Qualitative Research Interviews

To contextualise the potential challenges associated with my dual-role, I knew that having awareness of and acknowledging the commonalities and differences between clinical and research interviewing was important. Despite both interview types being considered a privileged and valued opportunity to be respected and not squandered, purpose and outcomes vary.

Modern day occupational therapy interviews tend to promote the unfolding of an occupational history or story (Baptiste, 2017), much like that encouraged in a narrative inquiry where participant stories are privileged. An occupational therapist will often start their therapeutic relationship by inviting a descriptive story from each of their service users, beginning with an open-ended question which invites their patient or client to "tell them about" what brought them into their care. However unlike a research interview, the purpose of an occupational therapy interview is to identify occupational performance or participatory issues that are limiting engagement in occupational roles, as influenced by aspects of the person, the environment, and/or the occupation itself, in order to develop a therapeutic intervention plan (Hocking & Hammel, 2017). Many settings where occupational therapists work, such as hospital inpatient settings, demand a deductive interviewing style designed to narrow the focus of therapeutic inquiry, often the result of time and resourcing limitations. In a narrative inquiry research project, a deductive approach is counterproductive. It risks limiting each study participant's ability to richly describe and detail their experience under study, potentially stifling narrative opportunity.

Before conducting my first qualitative research interview independently, I spent considerable time familiarising myself with a variety of qualitative research interviewing literature, learning about purpose, strategy, and technique, as well as possible precautions to hopefully avoid (Braun & Clarke, 2013; Brinkmann & Kvale, 2015; Britten, 1995; Hunt et al., 2011; Mishler, 2009; Riessman, 2008; Roberts, 2020; Seidman, 2013). I also accepted an opportunity to participate in a joint interview with my primary PhD supervisor (Dr Meredith Tavener). Participation in this joint interview provided practical insight into how qualitative researchers may initiate and introduce the research topic, incorporate an interview guide within the context of a semi-structured interview, and conclude the interview, all of which differ from an occupational therapy clinical interview. This experience provided an opportunity to observe and learn from an established researcher during the act of qualitative interviewing, as well as discussing and reflecting on techniques used throughout the interview, at its conclusion.

It was through a process of education and practical observation that I became aware of strategies to employ before, during, and after a qualitative interview, to ensure a productive and successful data gathering experience. I was particularly mindful of cultural and power dimensions that may arise in a research environment which may differ from a clinical environment, as well the importance of being prepared to deal with emotionally charged situations that may arise unexpectantly during the course of a research interview (McGrath et al., 2019). Much has been written about potential power imbalance between researchers and participants within research interview contexts (Brinkmann & Kvale, 2015; Josselson, 2007; Seidman, 2013), and as such, I was conscious of minimising possible asymmetry by establishing a comfortable, relaxed atmosphere with each participant at all stages of our relationship. During both telephone and face to face interviews, I transferred skills from what

we refer to within the occupational therapy profession as the "therapeutic use of self" (Solman & Clouston, 2016), whereby I intentionally planned and used my perceptions, judgements, and personality to actively adapt within each encounter, establishing and maintaining rapport and building a safe and positive space.

Discussing traumatic events such as stroke and its impact on life means there is always the potential for sensitive or distressing issues to arise throughout the course of an interview. I was mindful, however, that wherever there is potential for harm, there is also potential for growth. Research interviews can provide a space for reflection as long as the interviewer is prepared and adequately trained to provide participants the support they need (Josselson, 2007). As an occupational therapist with eleven years of experience in acute stroke care, I have had the necessary training and extensive interviewing experience to ensure due diligence, whilst maintaining competency and compassion. During each interview I was attentive and sensitive to stories involving intense feelings and grief, offering psychological support and rest breaks to alleviate the potentiality of emotional exhaustion. As each interview came to an end, I would turn off the audio recorder and spend extra time reflecting over the interview with every participant. Despite emotions surfacing during some interviews, no one stated or appeared distressed afterwards and every participant expressed gratitude for the opportunity to share their stories.

Not dissimilar to my experiences working within clinical environments, I was afforded a trusted position by interview participants, initially related to my association with the university facility and each individual participant's experience with the research thus far. For interviews to achieve a richness and depth that reflect and encompass experience, an open and empathic environment needs to be created to support safe storytelling. Stroke survivor, caregiver, and therapist participation was initially influenced by prior association with the RCT. During interviews, stroke survivors and caregivers discussed the inherent trust they had in this project prior to enrolling, given its institutional link to the University of Newcastle. Each participant was provided with informal information about this qualitative study, either by the Trial Manager or myself, during invitational conversations seeking interest or obtaining informed consent. Participant expectations about interview length and content were likely influenced by these conversations, supported by the type and degree of information provided within the Participant/Carer/Therapist Information Sheet. Trust established through prior goodwill supported the formation of ongoing rapport between the study participants and myself, thus enabling open and honest in-depth interviewing.

Prior to each interview I carefully reviewed the semi-structured guide, and probing questions were mindfully considered and arranged according to their intended purpose. For example, prompting questions encouraging descriptive storytelling, such as "tell me more about that" and "in what way?" were differentiated from sense making prompts such as "what does that mean?" or "why did that matter?" to ensure exploration of meaning making in narrative context. Even seemingly simple acts during an interview, such as only asking one question at a time so as not to overly direct or perhaps divert a narrative thread, was an important consideration. Upon reflection, this preparatory time was invaluable. It provided me with the knowledge and confidence required to ensure that efforts undertaken throughout the entire interview process would support my goal of providing each participant the opportunity to share their storied experiences in a safe space, in order to shine a light on the research question.

Dual-Role Experiences and Challenges Throughout the Qualitative Interview Process

Some dual-role experiences can cause discomfort and anxiety for clinician-researchers due to the accompanying ethical and methodological issues that these experiences have the

potential to raise. Issues such as role obligation and role conflict may influence expectations of research process and outcomes, particularly when research is conducted within participant homes and researchers become guests, hosted by participants (Cartwright & Limandri, 1997). Other issues such as denying professional socialisation and ideology, whether intentional or not, may influence the lens through which research is analysed and interpreted (Colbourne & Sque, 2004). Such issues can be particularly difficult for novice clinician-researchers to negotiate, as they may not understand or be fully cognisant of the implications these challenges have on data collection and research quality.

Often such challenges occur *during* the interview process, where despite pre-preparedness, there is little time for reflection. In this situation, the clinician may retreat to well-developed and familiar clinical decision-making habits. Although offering a valuable opportunity for reflexive practice, adopting a "clinical skin" or seeing the situation through "clinical eyes" (Hay-Smith et al., 2016, p. 12) may not be for the betterment of the research project overall. If not during, issues may come to light *after* the interview has concluded, either during the process of transcription or early analytical phases. Identifying instances or occasions when a clinician-researcher may have adopted a solutions-focussed clinical reasoning approach, rather than maintaining an openly reflexive inquiry, may be identified by the clinician-researcher or highlighted by supervisors for a student (McNair et al., 2008).

Novice clinician-researchers may encounter some or all of these situations before, during, or after each research interview throughout their research journey. Occasionally whilst participating in research interviews, I felt an odd sense of discomfort, anxiousness, or uncertainty that necessitated a retrospective period of contemplation. After each interview I spent time exploring these feelings and any uncomfortable inclination through journal writing, and further attended to these observations during supervision sessions. Additionally, conducting this critical contemplation, guided through the lens of the typology of common catalysts of dual-role experiences, also helped me identify interview skill strengths and weaknesses, thus allowing for improved interviewing technique as I continued in my emergent role as clinician-researcher.

Learning from what Pillow (2003, p. 193) describes as "messy examples" can be instructive for future clinician-researchers. Although sharing these examples may reveal some naivety in my research approach, I consider the benefit for emerging clinician-researchers worthy of risking such exposure. As such, the following is a descriptive summary of the ethical or methodological challenges I experienced throughout the qualitative interviewing process, guided through the lens of the typology of common catalysts of dual-role experiences (Hay-Smith et al., 2016). Due to proactive decisions and actions taken prior to interview, certain themes described by Hay-Smith et al (2016) that may ordinarily elicit methodological or ethical issues for some researchers were avoided. These situations are also worthy of reflection, as avoiding potential conflict can be as valuable a lesson as learning from a situation after the event. For this reason, I have included some situations where upon reflection, ethical dilemmas or methodological conflicts were evaded for the betterment of the interviews that followed.

Clinical Queries: Challenge Averted?

"Clinical queries" may occur when a research participant requests information or reassurance from the health professional during the interview (Hay-Smith et al., 2016).

Clinical queries were rarely encountered during the interviews conducted, as I had made a prior decision to not disclose to the study participants my professional background as an occupational therapist, unless they specifically asked. All qualitative interviews were conducted at the conclusion of the RCT intervention period of therapy, and I was introduced to each participant by the trial manager (Dr Meredith Tavener) as a "researcher" from the

university. Assumptions and expectations surrounding the role of researcher were thus pre-defined. Not revealing my clinical identity to the majority of study participants limited the potential impact that my professional role may have had on the data generated during the interviews. If participants identified with me as an "insider" (Conneeley, 2002; Richards & Emslie, 2000), preconceptions of the role of therapist may have been assumed, potentially limiting or influencing the type of narrative detail provided during the interviews.

On one occasion, during an initial interview with a therapist involved in providing therapy as part of the RCT, I consciously made the decision to briefly refer to my own experiences conducting home visits, in an effort to further engage and extend the narrative around this experience. Other than this self-initiated disclosure, none of the stroke survivors, therapists or caregivers involved in the interviews enquired into my clinical background. Actively determining the role of researcher prior to the interviews had helped to establish tacit role boundaries within the interview process and thus mitigated the likelihood of a clinical query.

Despite most participants being unaware, the dual role of clinician-researcher still existed for me personally and consequently, the challenges did not diminish. It was still an issue that I was conscious of and remained vigilantly reflexive as a result.

Research or Therapy: Falling Back on the Familiar

"Research or Therapy?" may occur when clinician-researchers are concerned that participants are unable to distinguish between clinical and researcher relationships (Hay-Smith et al., 2016). When this occurs, clinician-researchers assume participants expect a therapeutic (counselling-type) response and that clinician-researchers may themselves feel heightened emotions and lingering feelings of unfinished business. Here, I will extend the "Research or Therapy" typology definition to include a concept related to my own experience of an over-reliance on narrative reasoning, which helps to explain how as a novice clinician-researcher, I assumed a therapeutic response during a qualitative interview involving an unanticipated narrative.

An unexpected dual-role challenge occurred during a second in-person interview with one stroke survivor. Following the first interview with this participant (pseudonym "John"), my reflections of the underlying narrative related mostly to an overall sense of positivity in the early phase of a recovery journey: a picture of hope; an imagined future of possibility contrasted against a backdrop of a life recently and abruptly interrupted by stroke. It wasn't flashing lights and fanciful dreams, but a story of everyday determination and dedication to return to the person he once was.

> "But, whether it was any good before the way it was is...it's my interpretation. Do you know what I mean? It mightn't, to you, it mightn't be any good the way it was, but to me it was what I'm aiming for" (John, stroke survivor).

Prior to the second interview, peering through a familiar yet subconscious clinical lens, I had an image in my mind of that imagined future. This process is often second nature for experienced occupational therapists, who use narrative reasoning as "an occupational life story editing process" that is client-centred and future-focussed, to aide intervention planning and outcome evaluation (Hamilton, 2018, p. 197). Occupational therapists often rely on narrative reasoning to guide therapeutic decision-making (Hamilton, 2018; Mattingly, 1998b). Narratives enable us to make sense of clinical happenings, thereby shaping decision-making. Additionally, story-making and storytelling is often used by therapists with their patients to influence the direction of future therapy (Mattingly, 1998a). Occupational therapists are known

to construct concrete images alongside their patients in the present day, projected into a futuristic, anticipated picture of self, where this narrative character holds hope whilst simultaneously bridging the reality of an illness experience (Mattingly, 1998a).

I had been looking forward to the second interview with John. From a researcher perspective, I was keen to hear more, willing and wanting to explore how things had changed with the passing of time. When the interview started and the stories I was being told didn't quite match the anticipated future I had subconsciously scripted, I found myself becoming uncomfortable and conflicted. How and where did this story fit? This narrative was an honest depiction of dreams not realised. In my role as a researcher, I wasn't in a position to provide meaningful counsel as the interview was not a therapeutic scenario. For me, the lines between clinician and researcher seemed to blur.

As a novice research interviewer, I was uncertain how to proceed. My natural inclination was to gravitate towards the more familiar role that I was most comfortable with; that of clinician. The interview could quite easily have shifted towards the therapeutic; however, the methodological risks of that included failure to explore experiences to the depth necessitated by the research question or the purpose of the qualitative research project, potentially diminishing the quality of the data being collected. There was also an ethical risk of failure to find a resolution for the participant within that interview context, particularly as there would be no further involvement from myself in the capacity as a researcher, and I was not his therapist. I did not want to diminish the significance of the unfolding narrative and perhaps privilege my perspective over that of the participant, as John was the one initiating the narrative. It was a tight rope that I felt poorly equipped to deal with from a novice researcher perspective.

The ethical and methodological dilemma I was experiencing has previously been described by Yanos and Ziedonis (2006, p. 3) as "an internal clash between the clinical mandate to act in the patient's best interest (beneficence) and the scientific mandate to pursue truth with all appropriate rigour (scientific autonomy)." Although feeling uncomfortable at the time, this dilemma became more obvious once I had completed the transcription and started familiarising myself with the narrative. There appeared to be multiple opportunities within the interview where I had avoided scrutinising meaning-making for fear of crossing over into therapeutic interviewing territory. Upon reflection, the interview with John appeared to be a hybrid, somewhat therapeutic and somewhat research-focussed. At the time, it felt like a failure, both for the participant in terms of not fully allowing and supporting narratives to avoid the risk of the situation turning therapeutic, and also for the project for not fully inviting a meaningful exploration of experience.

To continue moving forward, I spent many hours considering and reflecting upon how this situation occurred. Despite the complexities, I determined that although being aware of the possibility of qualitative interviews being at risk of "turning" therapeutic, it is important to understand how and why this may occur. Leaning into familiar clinically-oriented strategies of supporting and enabling study participants through storytelling can generate meaning making experiences during narrative inquiry interviews, where the opportunity to make and tell stories is a therapeutic act unto itself (Frank, 2013). Furthermore, ensuring availability of external supports and de-briefing opportunities following qualitative interviews are available for both study participants and researchers alike, is critical for the emotional security and safety of everyone involved in the research process.

Clinical Assumptions: Difficult to Avoid

"Clinical Assumptions" are described as areas of shared understanding that are presumed by the clinician-researcher or participant due to familiarity with the health condition, intervention, or professions involved (Hay-Smith et al., 2016).

There are multiple ways where assumed dyadic understanding has the potential to influence the data gathering and analytical process in a qualitative research project. Through prior readings and a discussion with my supervisor, I was conscious of this *before* my very first research interview. To counteract the potential influence of making clinical assumptions, I actively avoided familiarising myself with the participants' medical histories or viewing the quantitative assessment results indicating change in arm function following participation in the upper limb training program. This decision was initially an uncomfortable one, as in a clinical situation I would rarely enter a therapeutic relationship without this sort of information. For the occupational therapist, developing a clinical understanding of the patient is a foundational act in a therapeutic setting, where not only is an image of the patient formed, but the therapist is able to reflect on their previous experiences and consider how this may influence the therapeutic process (Cantin & Brousseau, 2017). In a research interview, however, by viewing the participant as the expert of their experience, I was able to learn from them in their own narrative.

Secondly, clinical assumptions may arise *during* an interview where a participant or clinician-researcher assumes knowledge and understanding from the other, and the opportunity to further explore meaning is not investigated by the researcher at the time. This may be due to an unquestioned preconception or taken for granted assumptions of dual understanding. This methodological challenge is exemplified through an exchange in the first of two interviews between myself and a male stroke survivor (pseudonym "Ian").

> Heidi: So how are you fitting all of these things into your day?
> Ian: Ah (chuckles) more or less, having a stroke is a full time job, you know that (laughs)
> Heidi: (laughs briefly)
> Ian: (laughs) It's a full time job. It's as simple as that. I'm just working on it to try and get as, as good as I can.
> Heidi: Okay. So what were you doing before you had the stroke?

By stating "you know that," Ian may have presumed understanding on my part. He continued with "It's as simple as that," perhaps indicating the obviousness of stroke being a "full time job" as perceived by him. At the time, I didn't question this assumption and went on to further explore contrasts in occupational time use before and since stroke. It wasn't until the analytical phase where the opportunity to further examine what he had meant by that statement seemed clear and necessary. Upon reflection, this seemingly obvious error in qualitative research interviewing technique may have been influenced by my extensive experience as an occupational therapist, working on a stroke unit and witnessing the intensity of rehabilitation environments, thereby sub-consciously relating to a description of stroke being depicted as a "full time job" and assuming dual understanding. Fortunately, I was able to overcome the risk of clinical assumptions limiting this participant narrative by firstly identifying the error of my ways, and secondly, by further exploring this concept in our second interview.

To avoid presupposing the meanings and understandings of others during interviews, questions that on first glance may appear quite similar, may be asked by the clinician-researcher. These sorts of questions run the risk of being perceived by the interviewee as repetitive and/or cause confusion, particularly when interviewing a fellow clinician. As an

interviewer who shares common clinical and professional space with peers or clinician-participants, it is critical to inform the interviewee that their perspective is important, that they are considered the expert in this scenario and that you are asking questions to avoid making potentially inaccurate assumptions. This is especially necessary for novice clinician-researchers, who due to inexperience in qualitative interviewing techniques and data interpretation or analysis, may be at a higher risk of presuming a shared understanding.

Summary

Ethical and methodological issues can arise when qualitative research is being conducted by clinician-researchers. These issues may be compounded when experienced clinicians are transitioning and adjusting to a new role of clinician-researcher, as clinical role familiarity may be unintentionally privileged above research requirements.

Reflexivity allows for the connection between the overlapping reasoning and decision-making processes made by experienced clinicians and novice clinician-researchers involved in data collection and analysis processes and consideration of how this may influence the research process. The process and outcome of self-reflexivity opens up an opportunity to further our understanding about how intuitive reasoning processes that flow smoothly and allow for quick in-situ decision making during therapeutic situations for the experienced therapist, may be counterintuitive in research interviews. Assumptions based on previous clinical experience and an awareness of the methodological consequences associated with traversing the tight rope between clinical and research interviewing by an experienced clinician – novice researcher is important, as unintended ignorance may alter and perhaps even hinder, data generation opportunities.

Acknowledging the sometimes-imperfect realities of engaging in qualitative research made visible by practicing "uncomfortable reflexivity" and sharing the messy examples can provide instructive moments for therapists looking to make the transition from clinician to clinician-researcher. Awareness and understanding of the complexities associated with the dual-role experience also allows for the establishment of appropriate supervisory and supportive structures for interview participants and researchers, all of which are necessary to further enhance and support novice clinician-researchers as they continue on their research journeys.

References

Baptiste, S. (2017). Communication in occupational therapy practice. In M. Curtin, M. Egan, & J. Adams (Eds.), *Occupational therapy for people experiencing illness, injury or impairment* (7th ed., pp. 79-89). Elsevier.

Bleakley, A. (2005). Stories as data, data as stories: Making sense of narrative inquiry in clinical education. *Medical Education*, *39*(5), 534-540. https://doi.org/10.1111/j.1365-2929.2005.02126.x

Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. SAGE.

Brinkmann, S., & Kvale, S. (2015). *InterViews: Learning the craft of qualitative research interviewing* (3rd ed.). SAGE.

Britten, N. (1995). Qualitative interviews in medical research. *BMJ*, *311*(6999), 251-253. https://doi.org/10.1136/bmj.311.6999.251

Cantin, N., & Brousseau, M. (2017). Canadian practice process framework. In M. Curtin, M. Egan, & J. Adams (Eds.), *Occupational therapy for people experiencing illness, injury or impairment* (pp. 105-114). Elsevier.

Cartwright, J., & Limandri, B. (1997). The challenge of multiple roles in the qualitative clinician researcher-participant client relationship. *Qualitative Health Research*, *7*(2), 223-235. https://doi.org/10.1177/104973239700700204

Colbourne, L., & Sque, M. (2004). Split personalities: Role conflict between the nurse and the nurse researcher. *NT Research*, *9*(4), 297-304. https://doi.org/10.1177/136140960400900410

Conneeley, A. L. (2002). Methodological issues in qualitative research for the researcher/practitioner. *British Journal of Occupational Therapy*, *65*(4), 185-190. https://doi.org/10.1177/030802260206500406

Cusick, A. (2000). Practitioner-researchers in occupational therapy. *Australian Occupational Therapy Journal*, *47*(1), 11-27. https://doi.org/https://doi.org/10.1046/j.1440-1630.2000.00195.x

Cusick, A. (2001). The experience of clinician-researchers in occupational therapy. *American Journal of Occupational Therapy*, *55*(1), 9-18. https://doi.org/10.5014/ajot.55.1.9

Frank, A. W. (2013). *The wounded storyteller: Body, illness and ethics* (2nd ed.). The University of Chicago Press.

Hamilton, T. B. (2018). Narrative reasoning. In B. A. B. Schell & J. Schell (Eds.), *Clinical and professional reasoning in occupational therapy* (2nd ed., pp. 171-202). Wolters Kluwer

Hay-Smith, E. J. C., Brown, M., Anderson, L., & Treharne, G. J. (2016). Once a clinician, always a clinician: A systematic review to develop a typology of clinician-researcher dual-role experiences in health research with patient-participants. *BMC medical research methodology*, *16*(1), 95. https://doi.org/10.1186/s12874-016-0203-6

Hocking, C., & Hammel, K. W. (2017). Process of assessment. In M. Curtin, M. Egan, & J. Adams (Eds.), *Occupational therapy for people experiencing illness, injury or impairment* (7th ed., pp. 171-184). Elsevier.

Hunt, M. R., Chan, L. S., & Mehta, A. (2011). Transitioning from clinical to qualitative research interviewing [Article]. *International Journal of Qualitative Methods*, *10*(3), 191-201. https://doi.org/10.1177/160940691101000301

Josselson, R. (2007). The ethical attitude in narrative research: Principle and practicalities. In D. J. Clandinin (Ed.), *Handbook of narrative inquiry: Mapping a methodology* (pp. 537-566). SAGE.

Josselson, R. (2011). Narrative research: Constructing, deconstructing and reconstructing story. In F. J. Wertz, K. Charmaz, L. M. McMullen, R. Josselson, R. Anderson, & E. McSpadden (Eds.), *Five ways of doing qualitative analysis: Phenomenological psychology, grounded theory, discourse analysis, narrative research, and intuitive inquiry* (pp. 224-242). Guilford Publications.

Liamputtong, P. (2020). *Qualitative research methods* (5th ed.). Oxford University Press.

Mattingly, C. (1998a). *Healing dramas and clinical plots: The narrative structure of experience*. Cambridge University Press.

Mattingly, C. (1998b). In search of the good: Narrative reasoning in clinical practice. *Medical Anthropology Quarterly*, *12*(3), 273-297. https://doi.org/10.1525/maq.1998.12.3.273

McGrath, C., Palmgren, P. J., & Liljedahl, M. (2019). Twelve tips for conducting qualitative research interviews. *Medical Teacher*, *41*(9), 1002-1006. https://doi.org/10.1080/0142159X.2018.1497149

McNair, R., Taft, A., & Hegarty, K. (2008). Using reflexivity to enhance in-depth interviewing skills for the clinician researcher. *BMC medical research methodology*, *8*, 73. https://doi.org/10.1186/1471-2288-8-73

Mishler, E. G. (2009). *Research interviewing: context and narrative*. Harvard University Press.

Pillow, W. (2003). Confession, catharsis, or cure? Rethinking the uses of reflexivity as methodological power in qualitative research. *International Journal of Qualitative*

Studies in Education, *16*(2), 175-196. https://doi.org/10.1080/0951839032000060635
Richards, H., & Emslie, C. (2000). The 'doctor' or the 'girl from the University'? Considering the influence of professional roles on qualitative interviewing. *Family practice*, *17*(1), 71-75. https://doi.org/10.1093/fampra/17.1.71
Riessman, C. K. (2008). *Narrative methods for the human sciences*. SAGE.
Roberts, R. E. (2020). Qualitative interview questions: Guidance for novice researchers. *The Qualitative Report*, *25(9)*, 3185-3203. https://doi.org/10.46743/2160-3715/2020.4640
Schell, B. A. B., & Schell, J. W. (2018). Professional reasoning as the basis of practice. In B. A. B. Schell & J. W. Schell (Eds.), *Clinical and professional reasoning in occupational therapy* (2nd ed., pp. 3-22). Wolters Kluwer.
Seidman, I. (2013). *Interviewing as qualitative research: A guide for researchers in education and the social sciences* (4th ed.). Teachers College Press.
Sharp, N. L., Bye, R. A., & Cusick, A. (2019). Narrative analysis. In P. Liamputtong (Ed.), *Handbook of research methods in health social sciences* (pp. 861-880). Springer Singapore. https://doi.org/10.1007/978-981-10-5251-4_106
Solman, B., & Clouston, T. (2016). Occupational therapy and the therapeutic use of self. *British Journal of Occupational Therapy*, *79*(8), 514-516. https://doi.org/10.1177/0308022616638675
Stynes, M., Murphy, T., McNamara, G., & O'Hara, J. (2018). Reflection-on-action in qualitative research: A critical self-appraisal rubric for deconstructing research. *Issues in Educational Research*, *28*(1), 153-167.
Yanos, P. T., & Ziedonis, D. M. (2006). The patient-oriented clinician-researcher: Advantages and challenges of being a double agent. *Psychiatric Services*, *57*(2), 249-253. https://doi.org/10.1176/appi.ps.57.2.249
Young, A. F. (2004). Becoming a practitioner-researcher: A personal journey. *British Journal of Occupational Therapy*, *67*(8), 369-371. https://doi.org/10.1177/030802260406700806

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Dr Meredith Tavener has 20 years+ experience as a qualitative health researcher. She conducts and advocates for authentic qualitative research as an integral part of implementation science. Dr Tavener is a leader in qualitative methods and has established an international and national reputation for her rigorous and mindful approach to interpretive research, ethical approaches to participant involvement and working with co-design and co-production. Dr Tavener coordinates and delivers innovative online courses in qualitative health methods for post-graduate students around the world. She has accepted over 50 invitations for conference presentations. She has built a reputation for her mentoring of ECRs and MCRs in qualitative methods and has also conducted 14 capacity building workshops in qualitative methods (since 2012) for PhD students, staff and community groups.

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