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What is This?

The movement of knowledge and benefit: the product of applied ethics and emotional intelligence to mental health research

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Abstract

This paper seeks to highlight that researchers can generate the potential for benefit to all stakeholders within the research process through maintaining a wide understanding of ethical and emotionally intelligent behaviours. A range of ethical perspectives is examined before introducing a model which highlights key challenges and benefits of undertaking research within mental health contexts. Excerpts from both current and recent projects are then applied to the model. Finally, it is argued that many of the most ethically challenging issues arise outside of the realms and remits of ethics committees, consequently requiring the mental health researcher to possess and develop his or her ethical and emotionally intelligent capabilities.

Keywords

ethics, mental health research, qualitative research, research relationships

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What is already known

The underpinning pillars of research ethics are widely accepted and can be readily found within national and international ethical frameworks guiding nurse researchers. Additionally, the participation of the users of mental health services within research projects has been increasingly supported as evidenced in the literature.

What this paper adds

This paper offers a shift of ethical emphasis away from the sole perspective of ethics committees and guiding frameworks to explore the contextualised, situated and arguably defining features of the research relationship. The paper also offers a model of understanding characteristics of this relationship, as well as how mental health user research participants contribute to, and gain from, greater societal understandings of mental health and illness.

Introduction

Qualitative research approaches are increasingly concerned with the ethics, politics and power differentials existing within research contexts (Guba and Lincoln, 2005). At the most basic of levels, the very act of seeking and disseminating the views of users and carers of mental health services may be argued as responding to diminished user and carer power by offering opportunity for representation of voice. Qualitative research findings containing what are perhaps the themed voiced views of mental health users and carers offer shared descriptions of truths that represent social traditions, which in turn underpin all our daily lives (Gergen, 1999). These traditions of truths are sustained and evolved through continual processes of meaning generation, through spoken or written language. Engaging in such meaning generation not only can sustain traditions of truths, but also – as may emerge from qualitative mental health research – can offer the platform from which to challenge cultural traditions such as stigma and ignorance toward the mentally ill. In turn this may culminate in a shift in societal beliefs which can benefit the user or carer participating in research.

This is, however, a simplistic view toward addressing the differences in power and influence of those stigmatised and socially marginalised because of their mental ill health. Through dominance and consequent influence, not only can their discourse agendas be set by others, but their alternative views and voices can be dismissed. As researchers we arguably need not only to place a spotlight on the lived experiences of the marginalised, but also be active agents in making research participation an opportunity to generate meaningful change.

Overarching considerations

Researchers are ever present and bring their 'selves' into each of the research encounters that they engage in (Danaher et al., 2003). Making up a part of this self is what Mayer et al. (2008) call Emotional Intelligence. Briefly, emotional intelligence can be understood as the capability to use both emotions and cognition to enhance our ability to perform tasks effectively, and is particularly relevant within the inter-personal relating that is commonly found within qualitative research. Within the context of undertaking high-quality qualitative

research, the capabilities of self-awareness and empathy are foundational to constructing an effective research relationship.

Clearly, this relationship does not dwell within a vacuum, but is placed within the context of the topic under investigation. Within mental health settings there arguably exists a 'disorderliness' of practice that must be recognised; as part of the context in which moral discourse in mental health care settings is conducted, decisions taken and behaviour enacted. Arguably, there is a necessity for having multiple frameworks to guide research relationships, respond to this 'disorderliness' and to seek congruence between the matrix of research ethics and the models that guide it (Coombes and Danaher, 2001). Indeed Coombs and Danaher (2001) highlight the importance not just of the research relationship, but also the ethical behaviours that frame that relationship.

Ethical knowledge is, essentially, a sense knowing what is good, or what constitutes right action. Ethical theory tends to be based on abstract concepts which call for judgement in their real-world application. Indeed, qualitative research can be carried out in a real world that is at times unpredictable, complex and even chaotic, suggesting that unforeseen emergent ethical contexts can arise (Clearly, 2004). The onus of applied research ethics can consequently be argued as sitting as much within the realm of the research relationship as the ethics committee meeting room that precedes undertaking the research. Adopting such a position in turn will direct the researcher toward the necessity of careful emotionally intelligent self-observation within that research relationship.

Guba and Lincoln (2005) offer a compelling view of the way in which knowledge and truth are generated (methodology) via research findings, and the relationship between research investigator and participant in relation to research ethics. Key constructs underpinning these interrelated constructs and informing our model are those of voice, reflexivity and representation.

The first of these, ethical considerations of voice, pertains to the multi-layers of voices present in any qualitative study, and the challenge of presenting the researcher's voice as well as the voices of the participants. In this sense the qualitative interview or focus group can be understood as the democratic conduit for increasing understanding (Anteliz et al., 2001).

The second of Guba and Lincoln's (2005) ethical concerns is reflexivity, or the process of engaging in critical reflection on self as researcher. The self we take to the research is in part a multi-dimensional notion of self requiring individual critical interrogation, as well as reflection, upon its relationship within the complexities of the research process (Bernauer and Rasmussen, 1987). The complexity and value of undertaking such reflexive exercises cannot be overstated. This dichotomy of adoption and repression firstly requires self-awareness to make the choice of which parts of self to bring into, or bracket off from, the research relationship. The researcher then requires the authenticity and emotional intelligence to avoid self-deception and hence be able to relate ethically with the user/carer research participant (Beech, 1999; Danaher et al, 2003; Fontana and Frey, 2005).

Representation, the third of Guba and Lincoln's (2005: pp. 209–210) ethical concerns, offers a challenge to researcher positioning through research findings being viewed as either representative of the world 'as is' or as negating and constricting other equally legitimate ways of being. Offering findings as 'a truth' within the context of the rules of specific social and temporal considerations rather than an 'absolute truth' is but one way of addressing this issue (Gergen, 2001). Such contextualising of dissemination asks the researcher to be simultaneously empathic to the position of the user or carer participant and keeping their own voice within the research findings. Consequently, careful ethical consideration of the

dissemination of research findings is required, as well as developing the capacity for empathic understanding. Researchers tend to acquire very real stakes in their ideas. Personal theories are conserved by the researcher in a relatively pure state, guarded against sullying or defilement, representing their world view of the phenomenon under investigation. Danaher et al., 2003 warned against this, employing the term 'simplification' to describe how the vast complexity of human life can be simplified to fit the researcher theory.

In an attempt to offer some response to these ethical concerns and the contexts in which they dwell, a model for mental health qualitative research ethics is offered (Figure 1). This model does not offer itself as a 'MacDonaldized' (see Ritzer, 1996) solution to complex research contexts, but rather provides a guide to potentially minimise differentials of power within the research relationship, and to highlight how the research relationship and new knowledge unleashed through that relationship can constructively reverberate back to all the research stakeholders.

The model explained

The model structure is loosely developed from Brofenbrenner's 1989 (Rowan, 2004) model of social ecology and commences with the mental health researcher and user/carer undertaking a relationship through the qualitative research process. This research process and relationship occur within a societal system defined, bound and partially constricted by the extent of current knowledge availability and knowledge utilisation toward mental illness. The nature of this relationship is, in part at least, defined by the purpose and ethics of the research. Kenny (2001) graphically illustrates the ethical imperative for research outcomes to make a difference in participants' lives through underscoring research participation as a personal investment to generate betterment. The model places the research participant at the source of making a difference toward their own quality of life. The very act of contributing toward self-betterment through the platform of the research process offers
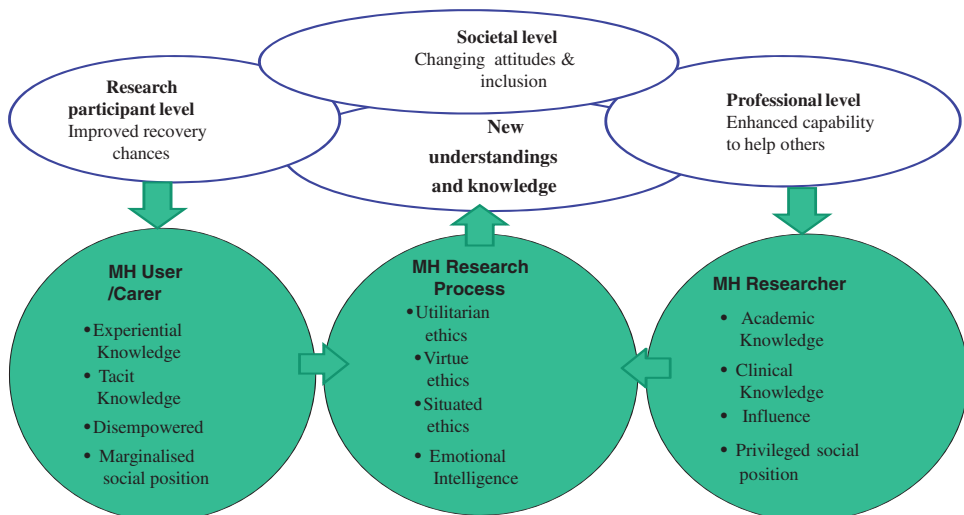

Figure 1. A model for mental health qualitative research ethics

the potential for diminishing the disempowered and marginalised position characterising many user and carers' lives. Consequently, the model commences with the participant and researcher being bound together through a research relationship underpinned by symbiosis.

Within the model the researcher's experiential level contains liberating elements inclusive of academic and/or clinical knowledge, as well as the complexity of bringing multiple selves into the research arena. Additionally, the professional researcher will hold academic and/or clinical perspectives and understandings of the issues being investigated, while the user/carer holds highly prized experiential and tacit understandings of the issues that the researcher seeks. Despite having these prized understandings, the user/carer will in all likelihood dwell within a comparatively stigmatised social position and will have, in comparison to the researcher, little power to influence or change fundamental aspects of their own experiences of mental illness and possible journeys toward recovery.

Of importance here is the recognition that mental health, and hence research directed toward mental health, is practised in different contexts to research conducted on general populations. The mental health patient's individual experience is frequently bounded by disempowerment and social stigma from others toward mental illness. From a research perspective this disempowered position demands identification and exploration to negate any filtration of mental health patients' narratives (Howard, 2006). Disempowerment and social stigma also act as potential barriers to the enactment of self-determination (Foucault, 1991).

Pertinent here is the need for respectful mindfulness that researchers and research participants dwell in different social contexts, hence creating a relationship of partial mutual 'outsidedness' (Anteliz et al., 2001). A failure to appreciate and take account of these asymmetries of power can only distort the research relationship and consequently the process, findings and potential gains for all stakeholders of the research. We view the model's interconnected nature of the researcher, research participant and societal levels as allowing the differing contexts to be responsively explored in an individual, situated way, enabling the flow and 'contra-flows' of power to occur, and minimising or neutralising the disparities inherently present. This movement creates the potential for an empowering shift toward the service user or carer that impacts upon the researcher and research process in a way that allows a more rounded recognition of the ethical problem and engendering a more context-bound, objective and collaborative attempt at resolution.

Minimising power differentials

The key to unlocking this potential for user/carer empowerment is the fluid application of multiple understandings of ethical conduct, supported by emotionally intelligent driven behaviours. The model suggests that the contexts of qualitative mental health research, particularly when user/carer focused, demand cognisance of utilitarian (risk vs. benefit), virtue and situated ethics.

Situated ethics adopts a position that, rather than timeless and universal codes of ethics being applied to guide ethical research, pivotal ethical issues are rather existentially 'situated' within specific research contexts. Consequently, ethical decision-making rests with those invested toward the research rather than removed and related to distant overseeing bodies.

Virtue ethics is an approach to ethics that places importance upon the character of the researcher as the means to achieve ethical research behaviours and hence ethical outcomes. This emphasis of situated ethics toward the interrelatedness between researcher and the

research process, and virtue ethics emphasising that developing personal virtues insures moral conduct, arguably adds a reflexivity and existential responsiveness within a humanistic framework (McKie and Swinton, 2000; Morrison, 2002; Roberts, 2004).

However, virtue ethics has been criticised for lacking action guidance and practical application (Begley, 2005), and in challenging the idea of altruistic 'situated' researchers, Danaher et al. (2003) suggest that a sharing of interests between researchers and researched groups risks misrepresentation. Additionally, there remains the issue of mental health research being predominantly conducted under a 'risk versus benefit' approach to ethics, usually within medically dominated ethics committees. We argue that, while 'risk versus benefit' ethical approaches frame research undertakings, within that framework there exists the unpredictability of human interactions within a qualitative mental health research relationship which consequently require individualised ethical responses. Arguably, these requirements call for the researcher to be an active agent within the research process. Offered within the model is that emotionally intelligent capabilities are inherently present within this process.

As briefly explained earlier, Mayer et al (2008) offer an understanding of emotional intelligence as being four branches of main abilities, each with subsets of hierarchical abilities that move from the fundamental to the more sophisticated. Central to this is that emotional intelligence is an ability that enhances the relationship between emotion and cognition. In relation to the model, key emotionally intelligent capabilities within the research process commence with the ability for advanced self-awareness toward the multiplicity of selves within the research process (inclusive of the ability to utilise the appropriate self-identity to individualised and situated ethical requirements). Additionally, the ability to manage emotion in oneself and others and flexibly to choose a course of action that 'best fits' needs is also pivotal (Mayer and Salovey, 1997).

The model applied: Stories from the field

Vignette 1 – Dementia Service Models study (Ramsay, 2011)

In this study, managers and mental health nurses from community teams were interviewed alongside patients and carers who received services from the nurses in the teams. The aim was qualitatively to compare responses about service provision between the groups to identify common values, good practice and areas for improvement relative to the service models explored. Patients with diagnosed dementia were involved to provide contemporary user accounts, via semi-structured interviews. Those with dementia were to have mild–moderate illness with Mini-Mental State Examination (MMSE) (Folstein et al., 1975) scores no worse than 18 out of 30, to try to ensure or maximise ability as accurate historians and to be able to consent personally to participation.

The first application of the model relates to attending a data collection interview at which it was discovered that the participant had forgotten their earlier signed indication to participate – but was still willing to consent. In this case we decided that offering the participant a chance to rethink their participation to see if a better time occurred was sensible and ethical practice. However, equally so, this decision could be argued as being dismissive of the participant whose very place in the study was due to their forgetfulness. In this example, the research team applied the model by determining participation (and hence contribution) to knowledge generation, and potential betterment of societal attitudes was merely delayed rather than negated. The situated ethics were that the individual was

forgetful and in offering an opportunity to rethink participation potential risks were addressed, while potential benefits were maintained.

A second example of ethical complexity relates to a participant starting an interview effectively but then becoming distressed, disorientated or unable to respond effectively. An ethical decision to terminate the interview could be made by the researcher to avoid further distress and the model applied by using the participant's earlier effective data and acknowledging their unique experiences, as an exemplar for those in similar situations.

Within both these examples the researcher had to make a judgement, hopefully to positively exercise the asymmetry of power in the researcher/participant relationship for the good of patient well-being (beneficence and non-malfeasance). This relates to the relationship views of Løgstrup (as cited by Holm, 2001) and Usher and Holmes' (1997) principles of maximal autonomy and mutuality within research.

Vignette 2 – The Caring and Life Management (CALM) study (Gall et al, 2003; Macleod et al, 2011)

The CALM study evaluated how effective a new nurse-led support intervention was on carer's needs, burden and service satisfaction by comparing this, within a quasi experimental study, to support normally provided by nurses. Case-study analysis, including semi-structured interviews, with nurses and carers was then carried out to provide contextual background to the success or failure of the new support intervention.

While vignette 1 applied the model to ethical decision-making, the CALM study is used to demonstrate the model as applied to highlighting the research participant as a co-contributor to the generation of improved potential health chances, knowledge and attitudinal changes. As the CALM project continued it was evident to researchers that life problems such as bereavement or relationship difficulties were impacting upon the carers participating in the study. Some carers also had mental health problems and reported fatigue, depression and/or stress.

The first application of the model to this study acknowledges that researchers and participants reside in different social contexts. Inherent within the interview process is the need to listen to, and carefully analyse, what participants are saying. This ultimately leads to greater reflection of issues by researchers and a possibility of narrowing this gap through learning to be genuinely empathic toward the position of the participant.

The second application of the model relates to role of the participants. An assumption inherent in much mental health literature and policies is that carers who experience negative consequences of caring are pathological and require professional support to 'cope/manage' (Rungreangkulkij and Gilliss, 2000). Indeed, some carers do experience depression or distress arising from caring, or report not managing or coping with difficult behaviour, crisis and relapse (Raune et al., 2004, Shore, 2006; Appleby, 2007).

Applying the model to the participants within this study places them within a different and arguably more empowered role. Rather than being the passive participant reporting their 'pathological or distressed' carer experiences they become the contributor of expertise about caring. Importantly, the model demonstratively places both the researcher and the participant in the role of being active agents to influence or change-negative aspects of the carers' experiences.

Conclusion

In exploring the clinical, social, moral and ethical complexities of research in mental health care we have proposed a model utilising a contextual, situated ethics and emotionally intelligent approaches to post-ethical approval to manage related remaining and emergent tensions. The model caters for the individual issue yet, we would contend, provides a responsive approach to a range of dilemmas (often unforeseen), given the interconnectedness of its professional, research participant and societal domains in generating new knowledge.

The model also offers an opportunity to re-examine the role and position of participants within mental health research that may offer benefit to all research stakeholders. The model also provides a means of expressing the flows and contra-flows of power and knowledge, within research relationships, which ultimately impacts upon all research stakeholders and, potentially, the wider communities in which we dwell.

Key points

- Power differentials between researcher and participant within mental health contexts requires a fusion of ethics and inter-personal capability
- Challenges emerge from the field work of research that necessitate a flexible and multiple understanding of ethical responses
- Through being a collaborative partner of the research process mental health research participants become active agents in changing their life contexts

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