Middlesex University Research Repository

An open access repository of

Middlesex University research

Ciclitira, Karen ORCID logoORCID: https://orcid.org/0000-0001-7222-0334, Marzano, Lisa ORCID logoORCID: https://orcid.org/0000-0001-9735-3512, Brunswick, Nicola ORCID logoORCID: https://orcid.org/0000-0002-6652-5016, Starr, Fiona and Berger, Sue (2004) Theoretical and ethical issues in conducting research at a women's health centre. Psychology of Women Section Review, 6 (1) . pp. 60-69. ISSN 1466–3724 [Article]

This version is available at:

Theoretical and Ethical Issues in Conducting Research at a Women's Centre

Karen Ciclitira, Lisa Marzano, Nicky Brunswick, Fiona Starr (Middlesex University)
and Sue Berger (Women and Health)

Introduction

This article will discuss research-in-progress designed to evaluate the counselling service at an all-women's centre, Women and Health. Women and Health was set up in 1986 in Camden Town, North London, following Ken Livingstone's authorisation of the donation of an old pub for use as a women's health centre. This vibrant charity has continued to grow and develop its services, and is currently run by two paid full-time members of staff and around 100 female volunteers. Currently more than 300 women a week who are unemployed or on a low income make use of the Centre.

Women and Health provides a wide range of classes and support groups, and various treatments including counselling, homeopathy, acupuncture, massage and nutritional advice. Services are charged on a sliding scale to ensure that they are affordable for most women. There is a part-time crèche, and special initiatives include the Asylum Seekers Project, projects for women with learning difficulties, and a Housebound Team which makes home visits.

The Counselling Service

The Counselling Service consists of 35 female volunteer counsellors and psychotherapists who provide long-term counselling. The current client group includes women with psychiatric diagnoses, young mothers with a history of abuse, women needing counselling in a supportive environment, women from minority ethnic communities, and older women without adequate emotional support.

It is increasingly difficult to ignore the increasing demand for so called evidence-based healthcare. The obsessive desire for centralised control, manifested by the insistence on the importance of quantification, has spread from academia and the National Health Service to voluntary organisations. Mental health carers are under constant pressure to provide practice-based evidence, to continually monitor performance, and to promote users' participation. In order to convince funders such as the Health Authority, Camden Council, the Community Fund, and other mental health trust funds to continue to finance the Centre, it was decided that Women and Health's services should be evaluated. A research team was formed comprising Sue Berger, the co-ordinator of Women and Health's counselling service, together with Nicky Brunswick, Karen Ciclitira, Lisa Marzano, and Fiona Starr (all from Middlesex University). There were many complex methodological and ethical issues which this team had to consider while trying to design a study which would both effectively and sensitively evaluate the counselling services.

Clinical Research and Methodology Issues

Evidence about psychological therapies comes from many different sources, including clinical case descriptions, systematic observational studies, intensive studies of psychotherapy process and process-outcome links, longitudinal studies of patient series, non-randomised outcome studies and randomised controlled trials. Randomised controlled trials are often considered the most rigorous way of producing evidence of what is effective, when comparing the outcome of one form of treatment with another (see Rowland & Goss 2000). However, ethical and practical issues often make randomised controlled trials with individuals suffering from mental illnesses problematic or impossible. There are disagreements as to whether research should rely on clinical judgements which are often unsystematic, or on psychometric measures which may be insufficiently subtle and excessively complex. There are advantages and disadvantages in both cases.

While there are various acknowledged methodological weaknesses associated with qualitative research, such as the problems of generalising data and issues of reliability (both constantly under review), some researchers argue that qualitative research may appropriately be considered 'reliable' and valid' if these terms are redefined. However, they may be insufficient to cover the multitude of complex issues involved in discussing evaluations of quality (see Kopala & Suzuki 1999). Feminist psychologists have long argued that qualitative research methods are important tools for understanding women's experiences in a variety of settings. They allow for the importance of context and sociocultural factors in research (e.g. Hollway, 1994; Kitzinger, 1995), and they have elicited useful insights into the process of effective and ineffective therapy.

Quantitative self-report data do not always match empirical data derived from other sources. While they have an advantage over qualitative interviews in that interviewer effects are removed (Schuman & Presser 1996), they themselves are prone to influence by factors such as social desirability, impression management and self-deception. Participants are thought often to overestimate the effectiveness of their psychotherapy in self-report measures; they are more likely to be negative about their psychotherapy in interviews than in client satisfaction questionnaires. When considering quantitative data, results may obscure the complexity of change and improvement. For example, psychological therapies may make individuals more self-aware, putting participants more in touch with destructive and depressive feelings and events in their lives, in contrast to being in denial about such problems at the beginning of therapy (Rowland & Goss 2000; Blount *et al* 2002). Thus, improvement as measured by a questionnaire may result in a worse score (Blount *et al*. 2002).

Using a quantitative measure involves establishing norms and involves social control. Standardised testing leaves out the moral evaluation that underlies the description and is rendered invisible and incontrovertible through the apparent impartiality of statistical norms. Chaos and complexity is repressed and left out of the research process (Burman 1994:19).

One of the difficulties in conducting this kind of research is that there is no way of knowing whether any changes which participants manifest following their treatment is: due to the counselling, their relationship with their therapist, their motivation, or something completely unrelated to their counselling at Women and Health.

Roth and Fonagy (1996) argue that research often fails to capture the complexity of the clinical situation. They suggest that a premature demand for rigour may discourage clinical curiosity, and that clinicians often work toward diversification and elaboration of technique in an attempt to meet the needs of particular patients. Sometimes this results in genuine and generalisable innovations, and sometimes in applications appropriate only to a single case. The critical task of good clinical research is to establish systems capable of distinguishing between these two outcomes – but ones that also manage the tension between clinical creativity and the need for demonstrable outcomes. There is an intrinsic tension between the internal validity sought by researchers and the external, ecological validity essential to clinicians.

Most clinical work is itself a qualitative process whereby psychotherapists work with individual clients and come to know the particular characteristics of that person. Because of the convergence in purposes and practice, many researchers and clinicians have found that qualitative research methods can be usefully applied to clinical settings to further understanding of the clinical encounter. The quantitative perspective alone is only sufficient if measures are regarded as a 'sorting and grading machine' in which patients are inert subjects of the investigation *and* if clear 'gold standard' criteria are available against which the measure can be validated. The sole focus on quantitative analyses may inadvertently shore up reductionism and become detrimental to the development of good measures and the appropriate use of, or modification of, existing measures; numbers and statistics distance readers from the text and language of the measure (Blount *et al*., 2002:152-3).

Blount *et al* (2002) found that psychometric measures were seen by mental health patients as depressing, upsetting, too long, and culturally offensive. Following their comprehensive study on patients' reactions to psychometric tests they recommend that service users should be involved in the development of future self-report measures. It is also commonly recognised that users' views are essential to positive service development (Rogers *et al*, 1993), research (Hanley, 1999a, 1999b) and clinical governance (Dept of Health, 1998).

Effective research practice often involves triangulation (i.e. combining quantitative and qualitative methods) to gain a richer picture of clinical phenomena, as multi-method studies can take advantage of what both traditions have to offer (e.g. Maione & Chenail 1999). The research team agreed that a combination of qualitative and quantitative methods should be used to evaluate Women and Health's counselling service.

Research Project

This research was subdivided into two projects to be run in parallel. It was designed to consider the particular context of Women and Health, with its combination of low-cost treatments and social support for women. It was thought essential to encapsulate the complexity of Women and Health's services while also illuminating specific areas which could be systematically measured. As with similar studies of community projects (see Archer *et al*, 2000), the design of research was constrained by the requirement that it should be acceptable to those who work at Women and Health and to those who use its services. In order not to disturb the therapeutic process it was agreed that questionnaires and interviews should not be administered during participants' counselling.

Questionnaires

All women waiting to start counselling at Women and Health are asked to complete a pre-treatment questionnaire collects detailed background information, including factors such as medical history, employment, housing situation, history of abuse and social support networks. Two post-treatment questionnaires will be given to participants when they have finished their counselling. These include a CORE questionnaire, and questions about how participants view the Centre and their counselling. The CORE questionnaire (Clinical Outcomes in Routine Evaluation) is designed to assess effectiveness of therapeutic outcome, and comprises 34 items which cover 'subjective well-being' (4 items), 'problems/symptoms (12 items), 'life functioning' (12 items) and 'risk/harm' (6 items). It has been standardised on a British population, and many other clinical services including those in Camden are currently using it.

Counselling Clients' Interviews

Approximately fifty new counselling clients are to be interviewed pre- and a post-treatment. In view of current research findings highlighting the importance of individuals' attachment histories (e.g. George & West 2001), these semi-structured interviews consider women's current and previous relationships, and collect information about their personal circumstances, physical and psychological health. The first interview is being offered to women who have been clinically assessed and who are waiting to receive counselling (it will not delay their counselling); the second interview will be offered to those same women when they have completed their counselling. The post-treatment interviews will also explore whether or not clients think that counselling has improved their health and wellbeing, reduced their isolation, and achieved other self-identified objectives. It will also explore how they view their current and past relationships, and Women and Health's services.

Counsellors' Semi-structured Interviews

Approximately fifteen counsellors and psychotherapists who have worked at the Centre for a minimum of six months during the past two years are to be interviewed. This

interview aims to elicit their views about Women and Health and its services, as well as provide information about their clinical work, training and theoretical orientation.

Theoretical, Methodological and Ethical issues

Theoretical and Methodological Issues

Attachment theory is currently viewed by researchers and clinicians as applicable to clinical practice of diverse theoretical orientations which work with different therapeutic modalities. The counsellors at Women and Health work with a diverse range of theoretical models, but attachment theory arguably provides a theoretical framework for understanding the principles which underlie all effective therapies (see Cleary 1999).

Attachment theory holds that secure and mutually gratifying relations are central to human existence. Closeness and comfort are seen as leading to a relational autonomy in which personal change can occur within close relationships (Bliwise 1999). Many clinical researchers accept that certain complex clinical findings can only be communicated by narratives (Leuzinger-Bohleber et al. 2003). The researchers here are interested in the way the women construct their life narratives, and reflect on events and their attachments to others. We are not just interested in *what* the women say, but in *how* they tell their story, both before and after their counselling.

Attachment theorists (including psychoanalysts John Bowlby and Donald Winnicott) have been criticised by feminists such as Erica Burman (1999) and Susan Franzblau (1999) for mother-blaming. Their work, it is argued, has been used as an effective tool to keep women out of the workplace, with negative effects on child care provision; and to promote norms such as heterosexuality and a so-called normal family life. Early attachment theorists neglected to consider different cultural values with regard, for instance, to childrearing practices and naturalised class and cultural privilege. For example, the value placed on maturity and autonomy within the West may produce a research bias (Burman 1999).

Attribution of the origin of adult problems to inadequate mothering in early life works to 'champion children at the expense of imposing guilt on mothers' (Tizard, 1991:183). It also treats social problems as originating in the individual (Burman 1999:81). Tizard (1991) asked 'what about father and other friendship and family ties?' Recent attachment research has considered considered cross-cultural issues (e.g. Ijzendoorn & Sag 1999) and different types of caregivers (e.g. Howes 1999). This research was designed to examine participants' care giving in all its forms, as well as considering the multiple and interacting components of the economic and social foundation of their caregiving.

The researchers propose to draw on attachment theory without categorising participants' attachment styles (e.g. avoidant, secure etc), which would merely label individual women and fail to capture the full range of attachment behaviour or its variability across settings (see Bliwise 1999:44-47). Overall, we believe that certain fundamental aspects of attachment theory can be usefully be drawn on to understand individuals who have

suffered deprivation throughout their lives and who suffer from chronic mental health problems such as depression.

Ethical Issues

Is this research ethnically sensitive? Among the issues are tensions which arise from the researchers trying to serve their needs as well as those of the Centre and the women who use it. There are also issues of power in positioning the researchers and the clinicians in the role of the 'expert' and the clients as 'other', the victims and the pathological. 'Women's oppression within mental health systems, as elsewhere, intersects with other marginalized positions of disadvantage, in particular those clustered around structures of radicalization and class' (Bondi & Burman 2001, p.8).

Counselling should be a private experience. Are the researchers intruding on this process and becoming informants (Bollas & Sundelson 1995)? Similar issues include whether or not there is informed and voluntary consent; whether participants feel that they can refuse to volunteer; and whether participants are sufficiently informed to have a real understanding about this type of research and what they are letting themselves into.

Are the interviews too intrusive? Questionnaires may be safer and less intrusive than interviews:

> The research interview is an interpersonal situation, a conversation between two partners about a theme of mutual interest. It is a specific form of human interaction in which knowledge evolves through a dialogue. The interaction is neither as anonymous and neutral as when a subject responds to a survey questionnaire, nor as personal and emotional as a therapeutic interview (Kvale 1996:125).

Among complex issues with regard to researching women's lives which cannot be ignored are questions about the experience of different types of abuse. Not asking questions about this risks ignoring or minimising such experiences, whereas asking questions risks exposing women and breaching their privacy. Additionally, the researchers may be seen as sympathetic women and so granted special rights of access to private areas of participants' lives, exposing the participants to greater possibilities of exploitation than quantitative positivist research (Finch 1984).

Whose data is it? Should participants have been involved in the design of the research? Do they have enough involvement in the research process? Can we encourage government bodies to sponsor Women and Health without compromising its services? Women and Health plays an role in welfare provision through women's largely unpaid labour, in response to manifest failures of statutory services. If more government contracts were to be awarded to Women and Health, this could reduce its independence and extend the influence of priorities determined by state agencies. Furthermore, the trend to professionalize activities such as counselling is unsettling (see Bondi & Burman 2001).

All researchers are biased. Feminist researchers accept that this is the case and try to deal with this issue by being reflexive; but being reflexive has its limitations. In this instance, we are all in academic jobs with two of us are working as mental health practitioners, while one has already had an extensive involvement with the Centre. What happens if our data depicts a negative picture of Women and Health, its services and clinicians?

Lastly, feminists such as Gloria Steinem have criticised the fact that therapy and counselling serve to displace external issues such as poverty and racism by focussing on individuals' *internal* world. There are intrinsic problems which can seem incompatible with doing this kind or research. In fact, it is difficult not to become paralysed, with resulting inertia and unproductive stasis. Therapeutic and research discourse serve to construct categories of people with stigmatising labels, including women, lesbians and people of colour. Can this research adequately address these issues by contextualising them socioculturally and historically?

The issues raised here only touch the surface. The problems with carrying out good enough ethical research in this area are numerous, and compromises have generally proved necessary. More such issues will undoubtedly be raised during the course of this research, and it remains to be discovered whether the project proves useful for those that use Women and Health's services and for those who work there.

Acknowledgements

References

Archer, R. & Forbes, Y. (2000). An investigation of the effectiveness of a voluntary sector psychodynamic counselling service. *British Journal of Medical Psychology*, Vol. 73: 401-412.

Bliwise, N.G. (1999). Securing Attachment Theory's Potential. *Feminism & Psychology*, Vol.9 (1): 43-52.

Blount, C., Evans, C., Birch, S., Warren, F., & Norton, K. (2002). The properties of self-report research measures: Beyond psychometrics. *Psychology and Psychotherapy: Theory, Research and Practice*, 75:151-164.

Bollas, C. and Sundelson, A (1995). *The New Informants*. London: Karnak.

Bondi, Liz & Burman, Erica (2001). Women and Mental Health: A Feminist Review. *Feminist Review,* No. 68, Summer, pp 6-33.

Franzblau, S. H. (1999). Special Feature. Attachment Theory. In *Feminism & Psychology*, Vol.9 (1): 5-52.

George, C. & West M. (2001). The Development and Preliminary Validation of a New Measure of Adult Attachment. The Adult Attachment Projective. *Attachment and Human Development* (3), 30-61.

Hanley, B. (1999a). *Involvement works: The second report of the Standing Group on Consumers in NHS Research*. London: Department of Health.

Hanley, B. (1999b). *Research and development in the NHS: How can you make a difference?* London: Department of Health.

Hollway, W. (1994). *Subjectivity and Method in Psychology: Gender, Meaning and Science.* London: Sage.

Howes, C. (1999). Attachment Relationships in the Context of Multiple Caregivers. In J. Cassidy and P.R. Shaver (eds) *Handbook of Attachment. Theory, Research and Clinical Applications*. London: Guildford Press.

Ijzendoorn M H. van & Sagi (1999). Cross-Cultural Patterns of Attachment: Universal and Contextual Dimensions. In J. Cassidy and P.R. Shaver (eds) *Handbook of Attachment. Theory, Research and Clinical Applications*. London: Guildford Press.

Kitzinger, C. (1995). *The Social Construction of Lesbianism.* London: Sage.

Kopala, M. & Suzuki, L.A. (Eds.) (1999). *Using Qualitative Methods in Psychology*. London: Sage.

Leuzinger-Bohleber, M., Stuhr, U., Ruger, B., & Beutel, M. (2003). How to study the 'quality of psychoanalytic treatments' and their long-term effects on patient's well-being: A representative, multi-perspective follow-up study. *Int. Journal of Psychoanalysis.*, (84), 263-290.

Maione, P.V, & Chenail, R.J. (2001). *Qualitative Inquiry in Psychotherapy: Research on the Common Factors*. In ch. 3. pp.57-88, *The Heart & Soul of Change. What works in Therapy*.

Roth, A. & Fonagy, P. (1996). *What works for Whom? A Critical Review of Psychotherapy Research*. Guildford Press: New York.

Rowland, N. & Goss. S. (Eds.) (2000). *Evidence-based counselling and psychological therapies. Research and Applications*. Routledge: London.

Schuman, H. & Presser, S. (1996). *Questions and Answers in Attitude Surveys*. Sage: London.

Tizard, B. (1991). 'Employed mothers and the care of young mothers', in, A. Phoenix, A. Woollett and E. Lloyd (eds), *Motherhood: meanings, practices and ideologies*. London: Sage.

Ciclitira, K., Marzano, L., Brunswick, N., Starr, F. & Berger, S. (2004). Theoretical and ethical issues in conducting research at a women's health centre. *Psychology of Women Section Review*, 6, 1, 60-69. ISSN 1466-3724.