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Commentary

Ambivalence of the Psychiatric Nurse Whose Role is Researcher/Clinician

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Abstract

Objective: The object is to describe the ambivalence experienced when one is both a psychiatric nurse researcher and clinician. **Methods:** Methods-current dilemmas for psychiatric nurse researcher/clinicians are explored particularly in terms of group psychotherapy research. **Results:** The researcher/clinician is to be more confident in the outcomes of practice. **Conclusion:** Implications for nursing practice are: (1) To describe the research/clinician process (2) To explain the advantage of this combination in performing group therapy (3) To emphasize the researcher/clinician enables nurses to be responsible for what they practice.

Keywords: Mental health; Nurse/Researcher; Psychotherapy; Group therapy

Introduction

The ambivalence of the nurse researcher/clinician is evidenced today: The term ambivalence is defined as:

"1. Simultaneous and contradictory attitudes or feelings (such as attraction and repulsion) toward an object, person or action
2. Continual fluctuation (as between one thing and its opposite)
3. Uncertainty as to which approach to follow." (https:.meriamwebster.com/dictionary/ambivalence)

I will briefly look at the role of psychiatric nurse researcher/clinician, group psychotherapy and my experience as a psychiatric nurse researcher/clinician.

The Role of the Nurse Researcher/Clinician

Reasons for the smaller numbers of nurses pursuing the researcher/clinician role are examined. There is disagreement as to the diverse avenues of focus, scope and validation of knowledge development in nursing [1-3]. In a more positive light is the agreement that science leads to a more rigorous outcome for nursing.

Methods

Current dilemmas for group psychotherapy research

In response to the rigorous experimental design, clinicians frequently cite the irrelevance of psychotherapy research findings and the limited external validity [4]. Treatments that result from randomized control are not always useful to a patient in real life [5]. Clinicians determine the focus, define priorities, and research strategies for implementing the results [4,6,7].

Greene [8] and Leszcz [9] discuss a "warming trend" for the research and practice domains. Group therapists are more likely to be effective if they build strong relationships with their clients marked by: 1) empathy, warmth, and respect; 2) attunement to diversity; 3) developing and sustaining group cohesion; and 4) utilizing countertransference effectively. Deliberate practice includes the thoughtful review of challenging groups and sessions, planning for future sessions, and opening oneself up to feedback and consultation. They argue to combine quantitative and qualitative methods, experimental and quasi-experimental strategies. They also advocate for the dual role of researcher/clinician.

Results

Author's experience as a psychiatric nurse researcher/clinician

The author has conducted research while leading a unique psychotherapy group for many years. This group is in a psychiatric hospital for people who have exhibited assaultive behavior.

See the Concentric Interactive Psychotherapy Group (CIPG) for more detail [10-12]. The CIPG is innovative in its structure, process and participants. The CIPG engages patients, co-leaders, and staff observers in three different concentric, or embedded, groups. Each 75-minute CIPG meeting consists of three phases, each of which involves three differently constituted participant groups.

In Phase 1 (45 minutes) patients form a group, led by two co-leaders. Staff members, who sit outside the group, observe.

In Phase 2 (15 minutes), staff form a group, led by the two co-leaders. Staff discuss their interactions within their own group and reactions to the patients' psychotherapy group. Patients observe at this time. During phase 1 and 2 there is no talking between patients and staff.

In Phase 3 (15 minutes), all participants (patients, staff, co-leaders) form one large group. All discuss their reactions and any change in their point of view during any of the three phases.

Initial anxiety

At first, the leader was excited about the group [11], there was much anxiety, including that of the leader. As the group began, she started to have doubts at the complexity of the task.

Safety was obviously of paramount concern within multiple levels of the administrative hierarchy. Psychiatrists with whom she had worked asked in a skeptical manner if she was certain that the outcome would be positive. Nursing staff members were reluctant as well. One male nurse was relieved when he heard a male recorder was hired. He had mistakenly assumed the recorder was also a "bodyguard".

Ambivalence is not only for the nurse researcher/clinician. The male patient is ambivalent about joining a group. "A paradox is faced by men, where a man in psychological distress must first possess confident boundaries containing his identity in order to join the group" [13]. He feels ambivalence toward the leader which extends from excitement about the group to fear that no one would attend. Membership in a group enhances personal risk and ambivalence about intimacy [13]. Issues of trust are essential. Men are looking for commonalities such as difficulty with their anger.

To become angry may reduce anxiety because anger externalizes problems, whereas anxiety internalizes problems. For example, "there is nothing wrong with me, there is something wrong with you". Anger reduces feelings of insecurity.

Patients want to know something about the group they will be attending. To decrease variation, I read the groups' purpose and requirements in the same way to everyone in the group.

Dilemmas

Ethical dilemmas can develop [14], for example, patients become angry initially when required to complete questionnaires although they had agreed to do it.

A potential conflict of interest for the researcher/clinician is that what is best for the patients may threaten the goals of the research. For example, one patient laid down on the floor saying he was having a seizure. He related his seizures to anger and stress. He had no history of having seizures. He refused to get up and kept talking. Hostility came from other members. Eventually he started to throw cans of soda as weapons. I had him leave the group until he calmed down and demonstrated better control ([14] p. 125).

Dilemmas occurred when the group dropped in numbers. There were not enough patients who remained to allow us to perform the necessary data analysis. When doing research, I will side with the clinician, make it a real-life judgment, and always put the needs of the patients first. For example, a man who was originally assigned to a control group came to the intervention group. It was at first not noticed until several sessions occurred. At this point we talked about this in the group and I decided to let him stay.

The research design must protect against bias in data collection procedures [14]. Using the random assignment of subjects, is ideal. Something could be offered to control subjects so they will actively participate in the study. The study could include the patients' in the experimental group and the control patients experiencing a traditional psychodynamic group for the same amount of time as the experimental group. Or as an example, experimental group could be offered to control subjects at the end of the research.

A further step would be to have four groups using the cross-sectional design.

The leaders should be the same for both groups [14].

	Experimental	Control
Leader	Leader A	Leader B
	Leader B	Leader A

"Another option is to have two groups but without random assignment of subjects to groups. A qualitative instead of quantitative design may be preferable in some cases. This qualitative design allows for examination of research themes and for the clinician to have a detailed description of the group process" ([14], p:122).

Ongoing clinical supervision to process the leader's feelings and examine group process is necessary." Feelings, fantasies, hopes, etc., must be addressed both from the position of research and clinician and from the combined role position ([14], p:124).

General Recommendations for a Research Design

The level of experience of staff involved, resources and time are important when considering research methodology. To assist either in developing the project or at least in reviewing it, there should be a research consultant ([14] p:122). Any project receives the multiple reviews by research committees that occur before it is either submitted to outside funding agencies or conducted within an institution.

"A precise research protocol, including a decision tree that eliminates the influences of the investigator" ([14], p:124). The Principal Investigator's (P.I.) influence important when creating the project and generally not when the project has begun.

Team members collect and score the data. During the supervision, the P.I. is guided in making interpretation or inferences about data. It should be done in collaboration with others to compare views.

"Quality control checks can be completed on data collection procedures at predetermined intervals. Inter-rater reliability is commonly used" ([14], p:124).

Conclusion

On one hand, the clinician believes that practice should be based on history and that group be considered for their patients. On the other side is the wish to have randomization and a control group for subjects. Combining the research/clinician permits the nurse to know more confidently if group therapy is effective and, if so, how and in what ways.

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Conflict of Interest

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