



## Commentary

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### What future for research in mental health nursing

This paper argues that mental health nursing research is in a poor condition. We believe that it has marginalized itself, and has effectively split itself off from developments such as evidence-based practice (Cochrane Collaboration). We will examine some of the reasons behind the current position.

We will argue that there is a history of research largely conducted on nurses and the nature of nursing. Much of this work uses methods that are completely unacceptable to any conventional research discipline. Many published 'research' studies amount to no more than anecdotal accounts of nurses and patients' experiences. Modern mental health services have complex problems that demand skilfully designed studies, executed with rigour and utilizing batteries of valid and reliable outcome measures. However, we firmly believe that several remedial actions could transform the current situation.

The first problem is that there is little more than a vestige of an infrastructure of mental health nursing researchers with adequate training. There are probably only a few dozen with doctoral qualifications and fewer still have any substantial research training or experience. When one scrutinizes PhD theses written by psychiatric nurses, many are based on qualitative and uncontrolled studies. To compound the problem there appears to be a considerable variation in pass standards for PhDs between universities, and some theses contain fundamental flaws of design, analysis and write up. Other professions consider a well-controlled study for a PhD as a starting point in research training. For example, many psychologists and psychiatrists have received research training at a post-doctoral level and have managed large grant-funded projects before taking senior academic positions. Sadly, there are professors of nursing (including those from a mental health background) who have no

substantial portfolio of decent peer-reviewed publications, let alone the experience of managing grants for large experimentally based projects. A priority is to establish an infrastructure of properly trained researchers. On a positive note opportunities for research training do exist. For example, the Medical Research Council and the NHS R and D Directorate have specifically recognized the need to train nurses for research. Other similar funds exist and are available to train for both doctoral and post-doctoral levels. However, the application rates from suitably qualified persons of a nursing background are low.

The second problem concerns the way in which (we) mental health nurses organize ourselves as research teams. Many mental health nurses seem to eschew the idea of working with a multidisciplinary team of researchers, although there is a rhetoric of multidisciplinary and teamwork. Mental health topics demand input from various perspectives. It is essential to group together not only psychiatrists, psychologists and nurses, but also pharmacists, statisticians and health economists. Statisticians are often overlooked when research grant applications are made, and, now that concepts such as statistical power need to be addressed in detail before a grant application is seriously considered, any team that omits the input of expert statistical advice does so at its peril. Health economists are also invaluable members of the research team as most health services research now has an economic dimension. This domain cannot be overlooked and a proposal for an economic analysis is now essential if a large research grant application is to succeed. The Research Assessment Exercise exposed the poor quality of nursing research, while at the same time showing that multidisciplinary teams reap rich rewards. For example, the Institute of Psychiatry gained a five-star (the very highest) rating by grouping all disciplines, including nursing, within nine specific research interest groups. Similarly the last Department of Health Research funding round (the Mental Health Initiative) awarded all of the major

grants to multidisciplinary groups, with unidisciplinary applications from doctors or nurses falling at the first hurdle. Nursing was a beneficiary in this process, with one particular (substantial) grant being awarded to a team lead by a mental health nurse.

The Mental Health Nursing Review (Department of Health 1994) emphasized the need to concentrate on research development and recommended ways of strengthening research. However, the review stopped short of defining research priorities. This was perhaps understandable, given that the NHS sets overall priorities for mental health research and these should be priorities for all disciplines. Nevertheless, within these priorities there are clear issues that should be the focus of mental health nurses.

The two specific areas that have been under-investigated are the testing of specific nursing interventions and the testing of different models of training. For many years, psychiatrists and psychologists have tested pharmacological and psychological interventions using the gold standard of the randomized controlled trial. With one or two notable exceptions (for example treatment by nurse behaviour therapists, Marks 1985) there has been very little testing of nursing interventions using this method. However, with a little thought, most nursing interventions could be tested by simple randomization procedures and many such studies can be executed at little or no cost. Instead, nurses have a history of examining the nature of the intervention and how it fits with nursing theory. There is of course a place for qualitative methods, but such research needs to use a rigorous approach and should be linked to quantitative methodologies, including outcome evaluation, for it to have any meaning.

Training is another area where research input is badly needed. We spend millions of pounds on training the workforce, yet most of these programmes are untested. The Thorn programme at the Institute of Psychiatry and the University of Manchester provides a model for training evaluation. Students identify four patients on their caseload who are followed up by a researcher over time. Measures of clinical and social function are collected in order to examine the impact of training on the patient. At the same time students' skills and knowledge are measured. The eventual aim is to test the training within a multicentre randomized controlled trial, but for the moment this evaluation

informs our planning and delivery. It is a pity that such methods are not more widely used to test training and that our National Boards spend their research budgets on studies that do no more than elicit the views of interested parties!

The long-term answer to the problem of providing a suitably trained research workforce lies in multidisciplinary education. There is no reason why nurses, social workers, psychologists and doctors should not be educated together for many topics, including research methods. Such programmes should have input from a range of professionals who adopt different theoretical standpoints and who may be able to share a wide variety of research experience. This is about to happen in the newly established programme on serious mental illness at Birmingham University.

It seems clear that mental health nursing research will take years to develop and flourish. In the meantime, it seems to us that our research will largely remain low in quality, targeting topics that are of little interest to any other profession and that confer no benefit on the uses of mental health services.

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## The methodology of choice: a reply to Gournay and Ritter

Gournay and Ritter raise several important points in their commentary on the state of mental health nursing research. Whilst I would agree that mental health nursing needs a stronger research base and that the way forward is to create more doctorate nurses and to foster a research culture, I cannot agree that we must adopt only the research methodologies of positivistic science. Mental health nursing, whilst being in part a science, can also be conceptualized as an art. Much of what Gournay and Ritter discuss must also be considered in the context of recent development in mental health

nursing education. The issues of PhD standards are not unique to mental health nursing and are due to recent structural changes both in higher education (HE) and in the education of nurses.

In 1992 the old polytechnics gained the right to become universities. Since this time there has been a growing concern in HE about the comparability and consistency of all degrees across institutions, particularly between the old and new universities. In the educational press there has been concern that degrees from new universities are possibly of a lower standard than degrees from old universities. However, there has been little objective research to show that the value of higher degrees varies across institutions. Even if Gournay and Ritter are correct, and PhD standards do vary between institutions, then the problem must be addressed throughout HE and not just within mental health nursing. If Gournay and Ritter have any objective statistics on variations in higher degree standards they would inform the debate by quoting them

The other major change in nurse education has been the move of nurse training from schools of nursing into HE. In many cases when schools of nursing have been absorbed by HE the original staff also transfer, often gaining the status of professor, senior lecturer and lecturer. Gournay and Ritter are correct to point out that some staff do not necessarily have a large and active research profile, but I would guess that those with poor research profiles are new academics drawn from the old schools of nursing. These new HE staff have come from an environment where clinical teaching of the highest standard was valued but it was not expected that all staff should be research-active. It is unfair to expect all of these new academics to suddenly develop research profiles. Instead their experience as nurse teachers should be valued and used whilst encouraging them to participate in research.

Gournay and Ritter make a more fundamental assumption that is clear in their statement discussing qualitative research methods '...methods that are completely unacceptable to any conventional research discipline'. Perhaps they mean that qualitative research methods are unacceptable to positivistic science, implying that mental health nursing is only a positivist science? Qualitative research methods are an established methodology of many non-science disciplines such as Philosophy or English. In these disciplines qualitative methodology is valued in its own right, not as a tool with

which to explore quantitative findings. Mental health nursing encompasses far more than the narrow philosophy that Gournay and Ritter describe. There are elements of nursing that are much closer to the arts, areas dealing with questions of our own humanity. Although quantitative enquiry is the methodology of choice when comparing, for example, the clinical effectiveness of nursing interventions, there are other questions that quantitative research does not address; fundamental questions such as: What does it actually feel like to live with depression? What do people need mental health nursing for? What do mental health nurses do? The answers to such questions will not be found through quantitative enquiry but through, to quote Gournay and Ritter, 'anecdotal accounts of nurses' and patients' experiences'. To address all of the questions facing mental health nursing both quantitative and qualitative research methodologies are needed, as equal but different partners.

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### **Research as power: a reply to Gournay and Ritter**

It is uncertain from Gournay and Ritter's text what constitutes a 'conventional research discipline' but nursing is obviously not seen as one. Psychology and psychiatry seem to fulfil the essential criteria and nurses are urged to learn the craft by collaborating with other disciplines. In so doing nurses would carry out valid, reliable research that meets the 'gold standard of randomized controlled trials'. In so doing nursing would gain the grant-attracting power of the other groups. Even within psychiatry and psychology writers such as Laing (1960) and Giorgi (1970) have disagreed with the positivist stance. However, within mental health nursing research into nursing interventions, a randomized control trial can neither be an effective measure of efficacy of the intervention nor, if we accept the view that relationships are constructed by people, even a possibility.

Gournay and Ritter are proposing that nursing learns to put forward research proposals that have a chance of being awarded large research grants. There is much emphasis on research collaboration. However, a notable absence from the list of possible allies is people in care. This indicates that the

power game in research is won by those gaining large grants and so impressing 'conventional research disciplines'. In this context research becomes something that we do to people in care rather than with them and as such research methods of a qualitative nature become devalued as 'anecdotal'.

The stories of science, reliability and validity are undoubtedly powerful but much of that power stems from the utility that these stories have had in the past. Science's story about the world is now being challenged in many areas, witness the recent rejection by the population of scientific assurances that beef is safe or that nuclear power is a safe form of energy. There are indeed examples of the 'science is power' approach being rejected by the purseholders. Hagan & Green (1994) for example researched the views of people in care using a phenomenological approach in order to plan community services.

There is an old Chinese proverb about the Stonecutter (Hoff 1982) that may be a warning here:

There once was a stonecutter who was dissatisfied with life. One day he was passing a great merchant's gate and saw how powerful and rich the merchant was. He wished to become that merchant instead of a humble stonecutter. Suddenly he was the merchant and was richer and more powerful than he had imagined.

One day he saw a powerful court official in a sedan chair flanked by servants and bodyguards and wished he could be that official. Suddenly he had indeed become that man and became feared by all the people.

However, it was a hot day and he found the sun made him hot and he wished for the sun's power. Suddenly he became the sun. He was immensely powerful but was blotted out by a cloud and wished to be that cloud.

He suddenly became the cloud and was powerful enough to blot out the sun but found he was blown away by the wind.

He became the wind and damaged buildings and trees. There was one thing however, that he could not move, an enormous block of stone. He wished he could be that stone and stood unmoved by anything, unchanged.

Until one day he heard a noise far below and looking down he saw a stonecutter.

Nursing may not have had the money attracting power of other conventional research disciplines

but we should not lose sight of our power being in how what we do works for the people in our care. That should remain a focus of our attention rather than an attempt to reinvent ourselves as something else that we deem at present to be more powerful.

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## Knowledge, power and authority: a response to Gournay and Ritter

I have always found that Angels have the vanity to speak of themselves as the only wise: this they do with a confident insolence sprouting from systematic reasoning. William Blake, *The Marriage of Heaven and Hell*, p. 52.

In their polemic *What future for research in mental health nursing*, Gournay and Ritter suggest that mental health nursing research is in a poor condition through not adhering to the positivist methodologies of medical science. It is tempting to respond to this unquestioning acceptance of the quantitative statistical paradigm with an equally polemical assertion that the most appropriate research paradigm for nursing is qualitative, holistic and humanistic, but for either paradigm to critique the other from its own perspective is, to paraphrase Philip Darbyshire, rather like criticizing a car for being a bad bicycle. Thus, rather than engaging in a slanging match about whether randomized controlled trials are better or worse than, say, grounded theory studies, I will attempt to critique the position from which either quantitative or qualitative researchers can make claims about ownership of the truth or of the methods for generating it.

Following the work of Kuhn, Feyerabend and the post-structuralist philosophers, it is now generally accepted (at least, in disciplines other than nursing)

that the methods by which scientific knowledge is generated are consensually agreed by the members of the academic community, and are constantly open to review and change. Furthermore, it is usual for different groups within each discipline to have differing ideas about what the 'correct' methods should be (witness the seemingly intransigent dispute in sociology between the positivists and the interpretavists). However, whereas in some disciplines there is a delicate balance of power and an ongoing debate, in others there is a clearly dominant position with dissenters being seen as irritating minority groups who are distracting from the main issues.

Until the mid 1990s, the balance between the qualitative and quantitative schools of research in nursing was so fine that many writers were coming to accept that both approaches had something different but equally important to offer to the discipline. The turning point in Britain came in 1994 with the publication of the *Report of the Taskforce on the Strategy for Research in Nursing, Midwifery and Health Visiting* (DoH 1994), which made three basic recommendations: firstly that health care research should be founded on large-scale studies that provide generalizable contributions to knowledge, and have as its 'gold standard' the randomized controlled trial (RCT) 'to set alongside the illustrious tradition of basic clinical bio-medical research', secondly that nursing research should be subsumed under a multidisciplinary rubric; and thirdly that 'the fundamental research task is to evaluate the effectiveness of clinical procedures, practices and interventions'. We can now begin to see where many of the ideas expressed in 'Gournay and Ritter's paper acquire their authority.

It is important to note that this favouring of one approach to nursing research over another was not itself based on a sound research foundation, but was rather a policy decision made by a taskforce of seven members, three of whom, including the chairman, were apparently not nurses. It is true that this decision was made following a period of consultation, but the process did not meet the rigours of a research study in any of its stages, from sample selection to data analysis. Furthermore, the report of the taskforce has permeated the infrastructure of nursing research and has informed policies on funding from the Department of Health (by whom it was commissioned) downwards, to the extent, as Gournay and Ritter point out, that it is almost impossible to obtain a major research grant for

anything other than a multidisciplinary controlled quantitative study, preferably a RCT, which measures some aspect of service outcome.

The report of the taskforce therefore represents an ideological stance that exerts an enormous degree of power and influence over the direction of nursing research, and had the taskforce been differently composed or differently predisposed, that ideological stance could well have been for unidisciplinary qualitative research to explore the processes of nursing rather than the outcome. In most discipline, including nursing, the dominant paradigm through which knowledge is generated is therefore related not to truth or to quality but to power.

What Gournay and Ritter fail to appreciate is that the gospel they are preaching is based on what is espoused by the nursing and medical establishment rather than, as they seem to believe, on issues of quality and appropriateness. How else can we account for the extreme arrogance of many of their statements: their assertion that much nursing research 'uses methods that are completely unacceptable to any conventional research discipline', their sweeping rejection of qualitative and uncontrolled studies (and of the people who write them); their condemnation of professors of nursing without 'decent peer-reviewed publications', and their criticisms not only of many nursing PhDs, but also of the universities where they were obtained. They associate quality with the holding of large research grants, with scoring well in the RAE, and with working in multi-disciplinary teams, in all of which, they tell us, the Institute of Psychiatry excels.

I wish to make three points in response to this position. Firstly, the history of science is littered, from the time of Galileo onwards, with discarded research paradigms. Indeed, so convinced were the Vatican authorities that the Earth was at the centre of the Universe that Galileo was sentenced to life imprisonment for daring to challenge this established theological world view and the paradigm on which it was based. No doubt the ecclesiastical authorities had become so narrowly focused on their own particular method of generating and verifying knowledge (the Bible) that they were blind to any other, convinced that because their method was supported by the establishment, it was not just the best method but the *only* method. Similarly, the Report of the Taskforce is in danger of becoming the nursing research 'Bible'.

Gadamer (1996) made the important distinction here between being *in* authority and being *an*

authority. The Church might have been *in* authority concerning the nature of the Universe, but clearly Galileo was *an* authority. Similarly, the bodies setting the criteria for nursing research might be *in* authority, but they are not necessarily *an* authority (indeed, as we have seen, three of the seven members of the taskforce were not even nurses). Thus, when Gournay and Ritter congratulate themselves on their five-star rating in the RAE, on their large research grants and on their substantial portfolio of decent peer-reviewed publications, they mistakenly believe that they achieved them for meeting some imaginary objective standard of quality rather than for playing by the rules and satisfying the criteria set out in the nursing research 'Bible' by those in authority. If the DoH set multi-disciplinary working and RCTs as criteria for obtaining a research grant, then RCTs conducted by multi disciplinary teams are bound to succeed over action research carried out by teams composed only of nurse. This, however, is not a judgement on the quality of a proposal, but only on its ability to meet the (some would say arbitrary) standards set by the funding body.

Secondly, there is a logical contradiction in their position. On the one hand they are bemoaning the fact that there is no infrastructure of mental researchers with substantial research training or experience. On the other hand, however, they are relying on these same colleagues: on journal review editorial boards; on the RAE nursing panel; and on research grant scientific committees; to bestow the rewards for playing the game. If, as Gournay and Ritter are implying, only a handful of these colleagues are trained and experienced for the job, then what is the value of the rewards they are handing out?

My final point is that Gournay and Ritter appear to be confusing the map with the territory, the game with reality. If, as they claim, mental health nursing research is in a poor condition, it is not because it is marginalizing itself but because it is starving itself to death. Of course there are rich rewards to be reaped by playing the multi-disciplinary game RCT, but to suggest that mental health nurses should focus on multi-disciplinary work and a medical paradigm to the exclusion of purely nursing research is, I believe, to make a fatal mistake that would spell the end of mental health nursing as a separate discipline. Our colleagues

from other professions are well-versed at playing the multi-disciplinary team game when it comes to applying for funding, but this does not preclude, or even relegate to second place, medical research or psychological research, and there are, of course, specific funding bodies for these activities. By advocating a predominantly multi-disciplinary RCT approach to mental health research for nurses, Gournay and Ritter are confusing the game of grant-seeking with the reality of what counts as useful and appropriate research. They are again attempting to measure the quality of research by the rewards on offer for following the party line, and by their own criteria, these are hardly 'valid and reliable outcome measures'.

If mental health nursing is to develop as a distinct discipline, then it requires its own unique knowledge base and its own unique methodologies for adding to that knowledge base. It could be, as Gournay and Ritter suggest, that the knowledge required by mental health nurses is related predominantly to the outcome studies required for evidence-based practice and that the only suitable method for achieving that end is the controlled experiment. It is far more likely, however, that what mental health nurses really need is a broad spectrum of knowledge, which can only be produced by an equally broad spectrum of research methodologies. The important point, however, is that whatever the needs of nurses might be, the way to address them is not through sniping and name-calling, which will only succeed in setting half the research community against the other half, but through a recognition of the impermanence and imperfections of *all* research paradigms and the knowledge that results from them.

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