Section Three: Critical Appraisal

Critical reflections on conducting interpretative phenomenological analysis with

implantable cardioverter defibrillator patients who have experienced multiple

shocks from their device

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This critical appraisal gives further consideration to particular reflexive and methodological issues that could not be fully explored in the empirical paper due to space constraints. A number of issues and challenges emerged during the study's completion that required careful consideration and decision-making. Though important in themselves, these issues were often somewhat tangential to the central focus of the paper. Reflecting on these issues here provides further contextual information regarding the study and an additional opportunity for me to critically engage with my work. I begin by reflecting on my decisions for choosing the topic and the methodology, discuss the degree of fidelity between my analytic approach and published guidance on undertaking interpretative phenomenological analysis (IPA), reflect on some of the ethical issues that emerged, and conclude with some reflections on the emotional impact the interviews had on me.

Why this project?

My reasons for choosing to explore the experiences of people who have received multiple shocks from an implantable cardioverter defibrillator (ICD) were both pragmatic and passionate. When I began my health placement at the cardiac centre that served as the research site, I was receptive to potential projects. It was during this placement that I first heard about ICDs.

My supervisor had begun to see increasing numbers of ICD-recipients presenting for psychological therapy after experiencing electrical storms. As part of my placement activity I helped her 'scope' a service for such individuals. This involved consulting the extant research into the psychological effects of ICDs and investigating the current

service pathway for ICD-recipients to see whether one could inform changes to the other. What began as curiosity quickly developed into passionate concern for ill people who had opted for a radical treatment in good faith, only to sometimes end up severely traumatised by it.

The complexities of this predicament stimulated me on both intellectual and emotional levels. I found myself wanting to understand more about how people who had experienced multiple shocks made sense of this experience, so different it seemed from other traumatising experiences. I wanted to discover how people coped with knowing they could be shocked at any moment, and that the shock would not just be painful in its own right, but would also constitute a near-death experience that the device was saving them from.

I felt a complex mix of emotions. I felt relief that cardiac patients had a treatment which, although potentially problematic, sustained their lives, and often without causing psychological difficulties. I felt sadness and anxiety about the brutal way ICDs delivered their therapy and felt frustration with the inappropriateness of many shocks. Mostly I felt a powerful sense of compassion for those who experienced psychological difficulties afterwards. Thus, when it became clear how little was understood about how people actually experience, make sense of, and cope with multiple shocks, and how they manage the ongoing threat of yet more, I became convinced of the value of undertaking a piece of research that might begin to answer some of these questions.

Why qualitative?

In order to reveal as much as possible about the experience of multiple ICD-shocks it felt important to approach the issue without preconceived ideas or theories about such phenomena defining the form that the investigation took. Furthermore, it seemed such a unique phenomenon that an exploratory approach was the only viable option; attempting a quantitative study felt like it would amount to a 'fishing expedition' without a qualitative one to identify credible avenues for such research.

Equally, qualitative methodologies fit with my sensibilities as a psychologist: they enable one to take an in-depth and person-centred approach to the research, respecting both participants' right to be heard and their uniqueness as individuals. While such methods can enable the identification of findings that may be applied to people outside of studies' samples, and typically point the way for subsequent quantitative research, they are generally not hamstrung by the tyranny of generalisability, which necessarily smoothes away much of the individual meaning-making that underpins psychological difficulties.

Why IPA?

IPA is a well-established analytic methodology for the purpose of conducting health-related qualitative research (Smith, 2011). Furthermore, Smith and Osborn (2008) argue it is particularly apposite for exploring phenomena that are novel, complex and that involve a process, all of which seemed pertinent to the experience of receiving multiple ICD-shocks.

There were two principal reasons why IPA was selected instead of other qualitative approaches, such as thematic analysis (TA) and grounded theory (GT). Firstly, unlike these other approaches, but congruous with the study's objective and my professional stance, IPA is fundamentally concerned with uncovering the 'lived experience' of a phenomenon and the meaning it holds for a person (Smith, 2011). This focus enables researchers to achieve a deeper level of idiographic analysis than that which may be afforded by either TA or GT, with their requirement for greater numbers of participants inhibiting such penetration.

TA was further invalidated by its tendency to limit itself to describing phenomena. Although some variants do adopt a more phenomenological stance (e.g. Braun & Clarke, 2006), arguably they do not accommodate the depth of analysis and interpretation enabled and required by IPA. By offering little interpretation of experiential phenomena, important aspects may be missed. These may exist outside of participants' awareness, necessitating the interpretation of a sensitive other to bring them into focus (Smiths, Flowers & Larkin, 2009). This highlights a further way in which IPA matches my professional stance: mirroring the relationship between IPA researchers and their participants, clinical psychologists are collaborators with their clients, utilising their expertise as interpreters to make sense of their clients' experience in a way that reveals what may have hitherto been obscured.

Rather than being concerned with detailing the 'lived experience' of a phenomenon, grounded theorists seek to reveal its essential characteristics so that a comprehensive, and therefore generalisable, conceptualisation of the phenomenon may be rendered (Charmaz, 2008). To a much lesser extent than in quantitative research,

idiographic nuance is a necessary cost of this generalisability, obscuring the individual at the heart of the research (Smith et al., 2009). Conversely, IPA is concerned with maintaining higher fidelity to participants' individual accounts and to exploring convergences and divergences among these. While this approach does not yield generalisable findings, IPA studies aim to utilise samples that are homogenous enough to potentially justify the transfer of findings to members of similar populations, and to provide enough contextual information so readers may do this in an informed and conscientious way. For these reasons, it has been argued that IPA is particularly suitable for understanding personal experiences, whereas GT is particularly suitable for understanding social processes (Willig, 2001).

Secondly, there was a pragmatic reason for selecting IPA over GT. GT necessitates a purposive approach to sampling, whereby recruitment unfolds iteratively on the basis of participant characteristics that will facilitate a comprehensive understanding of the phenomenon under investigation (Charmaz, 2009). The limited sample pool available to the present study meant the chance of gaining sufficient participants to meet either this criterion or to reach data saturation was minimal.

Thus, overall I felt IPA would best meet the study's needs, in terms both of its aims and of the sample available to me. I also felt it most closely matched my professional stance as a trainee clinical psychologist.

Fidelity of my study to IPA

In the Method section of my empirical paper I stated that the analytic approach I took broadly echoed IPA guidance. Although it is accepted that there is no definitive approach to conducting qualitative research in general and IPA in particular (Smith & Osborn, 2008), I feel it is important to define the specifics of my approach further here. Smith et al.'s (2009) guidelines for conducting IPA propose that such an analysis might unfold across six steps (See Appendix 1). I shall now account for the divergences between my approach and this guidance.

Step 3) Developing emergent themes. Smith et al.'s description of this step is conceptual, lacking detail about how to achieve the aim of reducing manifold initial notes down to a set of "pithy statements" (p.92) that capture their essence. It therefore felt necessary to develop a practical strategy to achieve this. I grouped the initial codes together into clusters by printing them out, cutting them up and physically rearranging them into different compositions. These groups went through various permutations before I discovered the most parsimonious and comprehensive version. I then wrote paragraph summaries of each cluster, essentially producing a set of themes for each transcript. Mindful of the interpretative focus of IPA, I italicised the interpretative elements of each summary in order to ensure a substantial level of interpretation was evident in each. I then wrote bullet-pointed summaries of each, which served as the emergent themes for each transcript. Though laborious, I felt this process lent a degree of concreteness to the guidance whilst also preserving IPA's spirit and purpose.

Step 4) Searching for connections across emergent themes. Smith et al. suggest the use of diagrams and charts to develop the emergent themes into 'super-ordinate themes'. The approach I adopted for identifying the emergent themes enabled me to draw these together, to find connections between them, and to highlight their most interesting and salient aspects; as this step of the process therefore seemed superfluous, I forewent it.

Step 5) Moving to the next case. Smith et al. recommend 'bracketing off' ideas that emerged during the analysis of one transcript to avoid contaminating that of the next with preconceptions. By slowly transcribing then analysing each interview separately, I was better able to immerse myself in the current transcript and quickly felt less distracted by preceding ones. I also sought my academic supervisor's opinion on whether the initial codes, particularly the interpretations, were sufficiently transcript-specific and uncontaminated by the others.

6) Looking for patterns across cases. Smith et al. recommend eyeballing tables or diagrams depicting the emergent/super-ordinate themes. In order to give this process more rigour, I printed out and cut up my emergent themes, then experimented with different permutations of them until I found the one comprising the greatest number of them. This involved looking for similarities and polarisations across all the emergent themes. Numerous emergent themes were necessarily discarded as they did not fit with enough of the rest of the data to contribute to a theme.

It is important to note that steps 3 and 6 unfolded not only iteratively but recursively, with emergent themes and final themes changing in light of periodic consultation with the original transcripts and, during step 6, in light of each other.

In summary, the approach I adopted was broadly similar to that recommended by Smith et al. I necessarily developed my own strategy for developing emergent themes due to the lack of specificity in the guidance and out of a wish to produce the most transparent analysis possible. However, I believe the approach adhered to the fundamental principles of IPA.

In order to evidence this claim, and mindful of the obvious pitfalls inherent to evaluating ones own work, I shall now assess my empirical paper using a method proposed by Smith (2011). He argued that IPA studies should demonstrate four essential qualities.

1) The paper should clearly describe the essential components of IPA; namely, phenomenology, the double hermeneutic and idiography. I described these in the Method and demonstrated them in the following ways. Regarding phenomenology, I sought to capture the nuances of participants' lived experience by asking open-ended questions that encouraged them to reflect on this experience. I ensured my analysis was phenomenological by constantly asking myself what each expression and emergent theme told us about their lived experience and by frequently consulting my IPA-experienced academic supervisor.

Occasionally, maintaining a phenomenological focus was difficult. For example, during Theme 4 the participants revealed that receiving more detailed information about shocks prior to having the ICD fitted would have had a detrimental effect on them. This initially felt more appended than integrated into the theme. Although it conveyed an important message that fitted the general theme of what constituted acceptable support

for the participants, it was not rendered in a way that revealed it as a dimension of their lived experience; instead it read like a list of recommendations they had made. By reconsidering this in light of IPA guidance I was able to ensure this point was communicated in a way that was consistent with the phenomenological nature of IPA. The double hermeneutic was evidenced by my effort to ensure that each participant's emergent themes contained substantial interpretation.

In terms of idiography, I preserved the individuals' integrity by producing biographies for each participant. I achieved sufficient depth of analysis by capturing divergences as well as convergences within the themes and by providing numerous supporting quotations from each participant. Idiography also encompasses issues of homogeneity. My sample was heterogeneous in certain key respects, not only in terms of psychosocial variables such as age, gender and socioeconomic group, but also in terms of their ICD-necessitating cardiac conditions. Although Smith et al. (2009) recommend that samples are as homogenous as possible in terms of "obvious social factors or other theoretical factors relevant to the study" (p.50), the paucity of extant research into multiple-ICD-shock experiences legitimised the engagement of a diverse sample. Without studies that might have enabled me to target a specific group it felt necessary to adopt an exploratory approach. This arguably paid off by providing a range of avenues for future research, some of which may not have emerged with a more focused sample.

b) The analysis should be transparent enough so that readers know exactly what the researcher did. I ensured this by clearly elucidating the process within the methodology and by providing a worked example in the appendices. I have supplemented this within

the present appraisal so that readers are aware of how the analytic process diverged from a published approach.

c) The analysis should be coherent, plausible and interesting. By producing narrative summaries of each participant's emergent themes, grouping these together in the most parsimonious and comprehensive way possible then writing the analysis up directly from these clusters, I believe that a high degree of coherence was achieved. I evidenced each significant point of the analysis with at least one quotation, conferring a high level of plausibility on the findings. Whether the analysis is interesting is, I believe, a matter for the reader to decide! However, I enjoyed writing it very much, which I take as a positive sign that people with an interest in this topic will find the analysis stimulating.

d) Sufficient sampling from the corpus to support findings. Smith (2011) proposes that at least half the participants should contribute to a theme for it to be credible. Each theme within my empirical paper was supported by extracts from every participant.

Ethical issues

I shall now consider some ethical challenges that emerged. Firstly, it seems important to reflect on my decision to exclude one of my seven participants ('Carol') from the analysis. This was not a decision I made lightly. I felt a deep responsibility to the participants; not only had they selflessly given their time, but each had done so in the context of deeply unpleasant and destabilising chronic health difficulties. However, despite meeting the inclusion criteria, Carol's shock-experiences distinguished her from the other participants in fundamental ways.

Carol had experienced five individual shocks, whereas the others' five or more shocks had occurred during electrical storms. Repeated physical pain, sustained feelings of helplessness and sustained contact with mortality emerged from the analysis as aspects of the other participants' shock experiences that profoundly affected their long-term wellbeing. Conversely, Carol's lived experience of the shocks was markedly different: she had only been aware of the three most recent shocks when they happened. Though painful and distressing, provoking the immediate concern that they might be deadly, because they were isolated and she perceived them as life-saving, she was neither perturbed by them beyond the discrete episodes nor did they have any discernible durable impact on her life.

IPA enabled me to make interpretations about Carol's resilience to the shocks on the basis of her life experience. For example, throughout her lifelong health difficulties, she felt the medical profession had never let her down; therefore she had a high level of faith in the treatments recommended to her. Echoing arguments made by Hallas, Burke, White and Connolly (2010), such experiences may have equipped her with greater resilience for coping with shocks' effects. However, as interesting and salient as such issues were, there was no way of integrating her experience with the others' in a meaningful way, as IPA guidance demands (Smith et al., 2009). Instead I found myself tacking her data onto the end of themes, rather than seamlessly incorporating it as evidence of the synthesised interpretations derived from the corpus as a whole. Although IPA is designed to accommodate divergences among participants, this assumes that the sample is homogenous enough in fundamental ways to attribute the variability within their accounts to psychological factors (Ibid.). That the other participants had

experienced electrical storms made Carol in effect an outlier, disrupting the homogeneity of the sample more fundamentally than could be accommodated.

I thus reluctantly remove Carol's data from the analysis. As difficult as this decision was, the problem of what to do with her data remained. I considered whether attempting to publish her account as a case study might be an effective way of ensuring her voice is heard. However, because of how unaffected she was by the shocks, I suspect there is insufficient material to justify such an article and it is unclear what it might usefully add. For this reason, I have chosen to remove the data and do no more with it. I have contacted Carol to provide her with a summary of the findings, to apprise her of my decision, and to apologise for having to take it.

Ensuring the participants' voices are heard is the second ethical issue upon which I shall reflect. Finding an audience for the findings is of paramount importance to me and is surely the most ethical way to treat the data that research participants have generously contributed. In addition to my intention to publish the paper, I have endeavoured to ensure that the findings impact on services at a local level and possibly beyond by disseminating the findings to consultants at the cardiac centre that constituted the research site and to representatives from the two ICD manufacturers who provide them with devices.

The third ethical issue I shall reflect on relates to the often unspoken omnipresence of death across the accounts. Managing these semi-disclosures required careful consideration of several factors. As a trainee clinical psychologist I was aware of the probable significance of participants' guarded allusions to death in terms of their

distress, both during the storms themselves and ongoing in the present; however, I was equally aware that probing such thinly veiled, distressing matters more deeply during the interviews was highly unethical. I came to this conclusion because in the context of a one-off interview I would have neither the relationship nor the time with the participant to be able to address such an issue in a way that would facilitate a measure of repair or, very possibly, even containment. Furthermore, the participants had not consented to psychotherapy and I felt that putting them squarely in touch with guarded, powerful feelings of this ilk and then working with the participants to contain them during the interview could be characterised as a psychotherapeutic intervention.

For these reasons I made the decision to ask questions that would enable participants to choose to make such disclosures, but resisted probing much further when they were made in a veiled fashion. This was not always necessary: 'David', in particular, was able to talk freely about these thoughts and fears. Conversely, both 'James' and 'Steve' betrayed significant difficulties with talking directly about their fears of death, other than in a very practical sense, and both betrayed significant distress during their interviews; I therefore felt it inappropriate to risk directly exposing these fears and the deep distress that likely underpinned them.

Fortunately in terms of the analysis, IPA enabled me to make the interpretative leap regarding this matter without having to probe the issue more deeply. I could elaborate on this subject within the analysis because of the centrality of interpretation to the approach. It assumes that what people say, think and feel is connected, but that this connection is complicated (Smith & Osborn, 2008), necessitating the researcher's sensitive interpretation. This feature of IPA allowed me to behave ethically during

interviews by not directly exposing that which participants were not ready to bring to their awareness.

The final ethical issue relates to the previous one. As much as disseminating the results to fellow professionals is a necessary and ethical stage of the research process, so is, I believe, feeding results back to those participants who have accepted the offer of such feedback. However, given the sensitive nature of this aspect of the findings in particular, I felt this needed to be done very sensitively, lest it provoke very difficult feelings in the absence of readily accessible support. For this reason, I wrote brief summaries of the themes, limiting the description of this theme to a comment on participants' fears that shocks might in themselves be fatal, and invited the participants to contact the cardiac centre's psychologist if they wished to discuss any of the findings in more detail. I felt that presenting the themes in a limited way met the ethical obligation for the participants to see the findings, but without their full extent being revealed in an uncontained, relatively unheralded and potentially destabilising manner.

Emotional responses

I shall conclude this critical appraisal by briefly reflecting on my emotional responses during and after the interviews. In particular, I frequently experienced sadness, anger and guilt. Sadness particularly for those whose distress was still ongoing, and anger for those whose shocks had occurred due to faulty devices. I think the guilt related to stirring up participants' feelings without being then able to work with them, and also to the faintly voyeuristic connotation associated with asking such questions without there being a

direct benefit to the individual concerned. However, this was tempered by participants' near-uniform unsolicited disclosures after their interviews that the process had helped them, disclosures which brought relief and a measure of pride. Furthermore, guilt reinforced my resolve to ensure the findings reach a wide audience.

Anger and guilt frequently occur to qualitative researchers during interviews (Dickson-Swift et al., 2007). Perhaps IPA, with its focus on lived experience, is especially liable to elicit powerful feelings. To help process these feelings I wrote them down after the interviews and sought supervision. This was especially helpful following the interview with James, whose age and stage of life most closely matched my own, and whose circumstances and ongoing distress provoked most sadness in me.

Conclusions

This critical appraisal has allowed me to articulate why I chose to explore ICD-recipients' experiences of multiple shocks in my empirical paper, to express my reasons for investigating these in the way I did, to account for divergences between my approach to performing IPA and published guidance, and to appraise my paper using an IPA quality assessment tool. I also used the space to reflect on a number of ethical dilemmas that emerged during the course of the study, and to account for how I addressed them. Two of these concerns highlighted some of the costs and benefits of undertaking IPA: a cost was that the demand for homogeneity led me to exclude a participant's data from the analysis; a benefit was that I was able to make interpretative leaps about a salient but very sensitive recurrent topic without having to expose difficult feelings. Finally, I reflected

on some of the emotional effects of the study on me, which highlighted some of the personal challenges and rewards of conducting this type of research in general and of being a clinical psychologist in particular.

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Appendix 3-A

IPA steps (Smith, Flowers & Larkin, 2009)

1. Reading and re-reading
2. Initial noting – descriptive, linguistic, conceptual
3. Developing emergent themes
4. Searching for connections across emergent themes
5. Moving to the next case
6. Looking for patterns across cases