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INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS (IPA): A QUALITATIVE METHODOLOGY OF CHOICE IN HEALTHCARE RESEARCH

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Abstract

This paper focuses on the teaching of the qualitative method, Interpretative Phenomenological Analysis (IPA), to healthcare professionals (HCPs). It introduces briefly the philosophical background of IPA, and how it has been used within healthcare research, and then goes on to discuss the teaching of IPA to HCPs within received educational theory. Lastly, the paper describes how IPA has been taught to students/trainees in some specific healthcare professions (clinical psychology, medicine, nursing and related disciplines). In doing this, the paper demonstrates the essential simplicity, paradoxical complexity and methodological rigour that IPA can offer as a research tool in understanding healthcare and illness from the patient or service user perspective.

Keywords

Interpretative Phenomenological Analysis; qualitative methodology; medical education; reflexivity; clinical health psychology; healthcare research.

Introduction

This paper describes one example of teaching qualitative research methodologies in the UK focusing on Interpretative Phenomenological Analysis (IPA:Smith, Jarman

and Osborn, 1999). The paper discusses the authors' experience of designing and delivering courses and workshops teaching qualitative research methods. The first author teaches qualitative research methods to GP tutors, specialist nurse practitioners, recently qualified doctors and other HCPs. The second author teaches qualitative methods to trainee clinical psychologists, and supervises research projects conducted by trainees, qualified psychologists and Masters students. Illustrations are provided of ways to encourage students to utilise IPA in their own qualitative research projects.

Qualitative research in psychology of health

Rigorous research methodologies form a necessary foundation of evidence based healthcare. Such a statement has, until recently, been read as referring solely to quantitative methodologies including the double blind randomised controlled trial (RCT), whose quantitative hegemony is in no way undermined by the advent of different but equally rigorous qualitative methodologies such as IPA. Quantitative methods are not intended to take healthcare professionals (HCPs) to the heart of the patient's lived experience: they rightly focus on matters such as treatment outcomes, survival rates and clinical governance. If, however, we are to regard healthcare and illness from the viewpoint of the patient, we must have appropriate and reliable technologies fit for purpose – and be ready to teach them to the people most likely to engage with them – healthcare professionals.

Only over the last decade and a half has it become accepted by many within the health disciplines that such research aims are most appropriately explored with the use of

qualitative methodologies (Henwood, & Pidgeon, 1992; Smith, 1996a, 1996b; The Psychologist, 1995; Turpin et al., 1997). Qualitative paradigms offer the researcher the opportunity to develop an idiographic understanding of participants, and what it means to them, within their social reality, to live with a particular condition or be in a particular situation (Bryman, 1988). It thus facilitates an understanding of the complexity of bio-psycho-social phenomena and, as such, affords exciting possibilities for informing clinical practice (Boyle, 1991).

The philosophical underpinnings of IPA

IPA has been specifically developed by Jonathan Smith (e.g. Smith, Harré and Van Langenhove, 1995) to allow rigorous exploration of idiographic subjective experiences and, more specifically, social cognitions. It is now widely used within British psychology (e.g. Duncan, Hart, Scoular, & Brigg, 2001, Thompson, Kent, & Smith, 2002; Clare, 2003; Biggerstaff, 2003; French, Maissi, Marteau, 2005; for a full list of published articles see http://www.psyc.bbk.ac.uk/ipa). IPA's theoretical underpinnings stem from the phenomenology which originated with Husserl's attempts to construct a philosophical science of consciousness, with hermeneutics (the theory of interpretation), and with symbolic-interactionism, which posits that the meanings an individual ascribes to events are of central concern but are only accessible through an interpretative process. Consequently, IPA acknowledges that the researcher's engagement with the participant's text has an interpretative element, yet in contrast to some other methods (e.g. discourse analysis, DA, see Potter, 1996), it assumes an epistemological stance whereby, through careful and explicit

interpretative methodology, it becomes possible to access an individual's cognitive inner world. A prime distinction between IPA and DA is that DA examines the *role* of language in describing the person's experience, for example, while IPA explores how people ascribe *meaning* to their experiences in their interactions with the environment (Smith, Jarman and Osborn, 1999). As such, it is especially suited to studies that aim to relate findings to bio-psycho-social theories that dominate current thinking within the healthcare professions (Smith, 1996; Willig, 2001; Smith, 2004).

In teaching and training healthcare professionals, either in the context of Continuing Professional Development or at entry Masters and Doctoral levels, the focus is frequently on the consultation between a professional and a patient, or on the psychosocial aspects of a particular condition or illness. Here, the patient's viewpoint carries the authority of service users as 'customer' or 'citizen' and indeed as expert (Sakala, Gyte, Henderson et al., 2001; Fletcher, 1996; Conrad, 1990). It is important to recognise that how people perceive and talk about their health is likely to vary, one to another, and may well differ from health professionals' perceptions. There are always (at least) two sides to any event in the health professional/doctor-patient interaction. It is equally important to remember that reports about the content of the clinical encounters, from the healthcare providers' perspectives only, frequently may not account for the perceptions or 'triggers' which lead people to seek care in the first place (Veitch, 1995). These triggers, or cues to action before health consultations, relate to patients' concerns and expectations (Van Dulmen, Fennis, Mokkink & Bleijenberg, 1996) and are commonly outside the perceptual field of the HCP.

Teaching qualitative research methods

As previously indicated, over the past decade and a half, scientific and medical journals, such as the UK's *British Medical Journal*, have acknowledged that a qualitative approach can highlight important areas of health research. This is especially the case in exploring health behaviours relating to patients and their psychological response to treatment, and in examining organisational behaviours such as implementing the process of change and modernising health service delivery (Murphy and Dingwall, 2001; Mays and Pope, 2000; Murphy, Dingwall, Greatbach et al., 1998).

While there is an acknowledged place today for the incorporation of qualitative research methods in the UK's standard psychology degree structure, awareness of qualitative research remains much less evident in the curricula of related disciplines such as medicine and healthcare. However, when professionals return to study as part of their ongoing professional development, they have a growing awareness of a need for qualitative research methods that can meet their professional and academic research requirements. The next section offers an account of adult learning – the educational context in which we teach IPA.

The adult learner

In considering adults learners, Malcolm Knowles' 'androgogical' model offers a framework for adult learning (Knowles, 1990). This includes:

- *The need to know.* Adults need to realise the reasons why they should learn something before they will undertake to do so.
- *The learners' self concept.* Educators need to be mindful that, since adults will draw on previous experiences of learning, students could revert to a previous identity - that of the passive, dependent learner. Lecturers need to encourage an adult psychological sense of identity in their students as self-directed autonomous people.
- *The learners' experience.* Adults bring to the learning situation their life skills and experiences. A group of mature adults is likely to bring to the lecture or seminar room a greater range of experiences and backgrounds than any group of 18 - 19 year olds can.
- *Readiness to learn.* Adults learn things as they need to know them e.g. learning about child development becomes more relevant (and thus more interesting) when a person starts a family.
- *Orientation to learning.* Adults are life-, task-, or problem-centred in their orientation to studying i.e. they learn most effectively when they understand how their learning can be applied to real-life situations.
- *Motivation.* Adult learners tend to be motivated by internal intrinsic factors such as increased job satisfaction, self-esteem and improved quality of life.

Kaufman applies this learning theory to medicine and healthcare settings. Using the concepts of self-directed learning, self-efficacy and reflective practice, he suggests that student anxiety or nervousness can be re-framed as excitement or anticipation (Kaufman, 2003). Newman and Peile, drawing on Knowles' work, observe that societal changes in careers have contributed to the rising numbers of experienced

learners in the workplace including adult learners in medicine (Newman and Peile, 2002). Emphasising the importance of a partnership model between learner and trainer they stress the relevance of experience as the driving force for reflection and learning. Against this background it is, therefore, important that trainers and learners adopt an educational style that is both flexible and reflective in order to help adult students learn about using qualitative methodologies.

The paper now moves to consider how the researcher employs IPA (for a more extended treatment of how to do IPA, see for example, Smith and Osborn, 2008). This will be followed by suggestions for teaching IPA drawing on our experience in the context of HCP education.

"Doing" IPA

The usual approach adopted by the IPA researcher is to collect data from (very loosely) semi-structured interviews where the interviewer has developed a 'prompt sheet' with a few main themes for discussion with the participants. It should be noted here that this 'interview schedule' is merely the basis for a conversation: it is not intended to be prescriptive and certainly not limiting in the sense of overriding the expressed interests of the participant. It is important that the interviewee take the lead during the conversation. Often the resulting interview data are very different from what the researcher might have anticipated.

After each interview, the recording is transcribed with meticulous accuracy, often including, for example, indications of pauses, mis-hearings, apparent mistakes and

even speech dynamics where these are in any way remarkable. The transcripts are analysed in conjunction with the original recordings and interview themes are identified which may or may not match those on the researcher's prompt sheet.

Data need not be confined to interviews. It is also possible to use multiple sources such as diaries where the researcher has asked people to keep a journal documenting their thoughts and experiences. Other useful sources include personal accounts, letters, or returns from questionnaires (e.g. where a blank space has been left inviting additional comment).

IPA analysis revolves round the close reading and re-reading of the text (Smith et al., 1999). The researcher makes notes of any thoughts, observations and reflections that occur while reading the transcript or other text. Such notes are likely to include any recurring phrases, the researcher's questions, their own emotions, and descriptions of, or comments on, the language used. At this stage the notes are used to document points that the researcher observes while engaging with the text. It is usual to record these initial notes in one margin of the transcript (Smith et al., ibid.).

While reading the text, the researcher attempts to suspend presuppositions and judgements in order to focus on what is actually presented in the transcript data. This involves the practice of 'bracketing' (Husserl, 1999: 63 - 65). What this involves is the suspense of critical judgement and a temporary refusal of critical engagement which would bring in the researcher's own assumptions and experience (Spinelli, 2002). As IPA acknowledges a role for interpretation, the concept of bracketing is somewhat controversial and in any event gives way to a more interpretative process as

analysis proceeds. This is one of the reasons why the IPA researcher usually keeps a reflexive diary that records details of the nature and origin of any emergent interpretations.

It is at this stage that the researcher moves on to re-read the text and identify themes that best capture the essential qualities of that interview. Carla Willig suggests that it is usually here that psychological concepts and terms may be used in an IPA analysis (Willig, 2001: 55). The researcher usually identifies themes from within each section of the transcript, and is also looking for possible or likely connections between themes.

Naturally, as in any qualitative analysis, the researcher may encounter material that seems not to fit the emerging picture. This is most evident in the occasional disconfirmatory 'case' where the individual's narrative or theme identified in that narrative is markedly at odds with most of the other participants (Smith, Harré and van Langenhove, 1995). Such dissonance will prompt the researcher, first of all, to revisit earlier transcripts in case something vital has been missed or misunderstood. Only then would s/he posit a disconfirmatory or contrasting theme.

The third stage involves attempting to provide an overall structure to the analysis by relating the identified themes into 'clusters' or concepts. The aim, at this stage, is to arrive at a group of themes and to identify super-ordinate categories that suggest a hierarchical relationship between them.

The fourth stage is to develop a 'master' list, or table, of themes. It is important to locate these themes in an ordered system that identifies the main features and concerns identified by the research participant. These are usually produced as a table with evidence from the interview, using a quotation which, the analyst feels, best captures the essence of the person's thoughts, and their emotions about the experience of the phenomenon being explored.

In summary, the method adopted by IPA is a cyclical process where the researcher proceeds through several iterative stages:

- Stage 1: first encounter with the text
- Stage 2: preliminary themes identified
- Stage 3: grouping themes together as clusters
- Stage 4: tabulating themes in a summary table

Further stages in doing IPA

This scheme can be applied to a single text. However, IPA is frequently used with more than one transcript, journal etc. The researcher can use the master list of themes obtained from the first interview to identify more instances of these themes in subsequent interviews, while also being alert to the possibilities of new themes. A second approach is to start the whole process afresh with the second or subsequent interviews and produce a list of themes for each interview. These themes are then drawn together into a consolidated list. Whichever path is chosen, the process is cyclical. New themes are tested against earlier data. In the light of later findings, the

researcher may need to modify the thematic analysis. Themes may become either subordinate or super-ordinate to themes found earlier.

The more material researchers have, the more rigorous they need to become in the later selection process. The mere frequency of a theme does not necessarily mean it should be selected as super-ordinate to, or more important than, other themes. The richness of the selected text and how the theme might inform other parts of an individual's account must also be considered. It is these fine nuances for which students most need support when learning about IPA. This paper now turns to consider challenges such as this when teaching IPA to adult learners.

Teaching IPA to clinicians and healthcare professionals: considerations for the tutor

While qualitative methodologies such as IPA have much to offer the researcher, and are attractive to clinicians wanting to research in a healthcare environment, the experience may be daunting for anyone, however experienced as a healthcare professional. This is where initial teaching and subsequent tutorial or mentoring support and indeed ongoing research supervision are vitally important. The IPA network and website (http://www.psyc.bbk.ac.uk/ipa) can (and does) provide additional support, but in our experience good quality supervision is essential if someone new to IPA is going to produce a useful and rigorous study.

Many of the standard requirements of good educational design apply to the teaching of IPA. Thus, it is important at the outset to offer students clear indications of the

structure of the sessions. This matters for its own sake as an aid to learning, and has further significance as exemplar and first instalment of a methodology which is clear, structured and self-disciplined. The essential simplicity of the approach can be explained and demonstrated while, at the same time, its capacity for complexity can be shown through its iterative processes.

By the same token – and more especially in the case of a subject-centred psychological approach – students are asked early on if they have particular expectations or needs for each session. The tutor has to be prepared to incorporate students' requests so that the teaching is appropriate for their prior experience and, later on, for the level of analysis they have reached.

Students who are just beginning research for a dissertation may need more guidance on structuring their interview schedule and discussion on interviewing techniques. In the case of practising and developing clinicians, for example, it is necessary to explore with them the differences between interviewing for research purposes as opposed to clinical purposes (Kvale, 1996). Indeed, in our experience this is an understudied and consequently under-taught area, and exploration of it often raises interesting ethical issues.

One, not infrequent example of this occurs, in our experience, when an interviewee expresses strong emotion - perhaps anger or grief - during the course of an interview. The interviewer may find herself unexpectedly with a possible conflict of roles: on the one hand, a researcher seeking information; on the other a clinician or psychologist, usually a compassionate person trained in specific skills that may be helpful to a

person in distress. Plainly, the interviewer does not, in this context, have a licence to practice counselling or psychotherapy, but what about deploying well-trained listening skills that may both assist the interviewee personally and, coincidentally, carry forward the research interview? Students need and appreciate the opportunity to discuss these ethical boundaries (Allmark et al., 2006).

In the case of teaching those without a background in psychology or/and who are receiving a single workshop, there is a need to include consideration of the epistemological differences between quantitative and qualitative perspectives and to provide detail of the psychological research context (namely health psychology) in which IPA has arisen as well as the types of questions that are most appropriately addressed by it.

This consideration leads naturally to the importance of learning by doing, drawing on adult learning theory (Knowles, op cit.). In practice, we have found that illustrating each stage of any didactic teaching with data excerpts from our own studies (for which informed consent has been sought and gained) helps to bring to life the process. The data selected for this purpose should be as close as possible to the likely interests of the students. Doctor students respond well to extracts from a recent research project where GPs give their views about risk and uncertainty and their role in helping female patients make decisions about hormone replacement therapy in relation to the risk of osteoporosis. Trainee Clinical Psychologists report finding having access to material (both interview schedules and transcripts) from previously completed Doctoral theses greatly assists their understanding of the process.

In addition, this linking of our research to our educational role is enriching and it also serves to help students see how their day to day work in healthcare can link directly to their own and other people's research. Moreover, the practice of worked examples offers an opportunity of feedback from students who are, in the rest of their lives, skilled people with much to offer by way of professional insight while simultaneously teaching-by-practising reflexivity (Finlay, 2003). This last point is integral to the process of IPA and, though arising as it were incidentally, can subsequently be made explicit as the flow of reflection builds up (see below).

It is essential that students have access to support and supervision at key stages in the planning and conducting of their IPA study. In addition to supervision from an academic, Trainee Clinical Psychologists using similar methods are encouraged to form reciprocal alliances with each other to enable 'peer supervision'. This promotes a range of adult learning opportunities as well as support. It can include role-play, and 'piloting' draft interview schedules, or, in some cases, audit of the analysis process as part of a quality control process. Both academic and peer supervision can play a key role in providing feedback and encouragement that students' early attempts at analysis are on the right track or that they need to re-think how they carry out their interview or their analysis.

Students nearing the end of their research analysis may need to be encouraged to move further in their analysis and to think more conceptually about the issues they have identified as themes from their data analysis. This is the move from categories and themes to super-ordination - the *interpretative* (second to third stage) stage. Moving away from a purely descriptive level of analysis often poses a difficulty,

probably because most HCP students have a prior grounding in positivist approaches, based on their training in evidence-based medicine (EBM) (Straus et al., 2005, Gray, 2001) and consequently may feel a sense of discomfort in making interpretations. It is understandable that people with a scientific training should not be willing to abandon that training or its underlying principles when engaging with a new (to them) approach to (qualitative) research. Yet this is where some of the challenges faced by students encountering qualitative methodologies (including IPA) has arisen. In our experience, this fear - though still encountered in some students, is groundless at both theoretical and practical levels.

At the theoretical level, our students are encountering the questions faced by Husserl and his colleagues which subverted the old dichotomy of subjective and objective experience. At the level of practice, they are grappling with the limits, in terms of usefulness, of descriptive information as a source of data that can stand on its own. All information has to be organised, they find, if it is to be of any practical use: and organisation requires organisers. The best organisers of information are those who work transparently, sharing their thinking at every stage.

Supervision can be useful at this stage in generating ideas as to how the emergent themes might be interpreted – although students do need to be reminded that any such ideas must be warrantable within the data and consequently checked out. Students sometimes comment that the IPA process, though essentially straightforward in its fundamental application, is paradoxically subtle and complex as the themes and super-ordinate categories emerge during the process of interpretative analysis.

Finally, students learn about the place of reflexivity in doing IPA. Reflexivity may be defined as both a central component of being human (i.e. the capacity to position the self) and also as the ability to reflect on and consider intersubjective dynamics between researcher and data (Finlay and Gough, 2003; Nicolson, 2003; Merrick, 1999; Hutchinson and Wilson, 1994). There is an apparent paradox here. IPA puts the experiencing subject at the centre of the endeavour. However, it is acknowledged that there is no such thing as "a view from nowhere" (Nagel, 1974) and that the researcher plays an inescapably significant part in the process. Rather than attempt the impossible task of seeking to diminish the researcher's role, IPA makes the positive step of acknowledging and exploring her role. The interviewer's thoughts and feelings are admitted as explicit and thus legitimate components of the enquiry, and their congruence or divergence from those of the participant are matters of proper enquiry. This dynamic position has implications, the most important of which is the need for students of IPA to develop the personal-professional self-awareness that underlies "reflexivity" (Finlay and Gough, 2003; Skultans, 1998). This reflexivity is deployed at each stage of doing IPA and, in the context of teaching IPA, is as much a requisite in the tutor as it is in the teaching process. Naturally, students bring to the task their existing capacity for reflexivity: the educational process and the teacher's activity should encourage, demonstrate and develop these capacities.

Teaching IPA to clinicians and healthcare professionals: what we recommend students should take away

In our academic practice as tutors, we have found that students value clear handouts that offer them PowerPoint or similar slides with attendant notes for immediate reference as they begin work on their own accounts. In our experience, students find it helpful if the reference list provided is specifically 'tailored' to their interests / speciality. There is now a large body of literature relating to IPA and related subjects and links are made in all sessions (practical as well as didactic) to the literature in order to encourage deepening of interest and a growing capacity for independence of judgement and practice.

Students are also given contact details for those occasions when they are in the field and need guidance as to what constitutes good qualitative practice. They take with them too the worked examples which have formed a central part of their learning and to which they have made a contribution.

Reflection

The students referred to in this paper are usually highly motivated but time poor. They are busy practitioners, typically studying at Masters or doctoral levels as part of their professional development. Qualitative research methods are frequently novel for them. This may be especially true for people with a medical background where all their training, beliefs and thinking about health and patients' behaviours have been shaped by a positivist quantitative, evidence-based perspective. For the many professionals who have not taken or been offered an opportunity to study IPA or another qualitative methodology, there remains a problem of credibility. This is seen most commonly where a researcher believes that personal reflection on, say, a patient

self-report, or a reading of responses to a patient questionnaire (typically conducted by a primary care practice manager) constitutes adequate qualitative research.

For the tutor or workshop facilitator, introducing students to a disciplined and structured qualitative viewpoint can be exciting and challenging – sometimes simply on the grounds that there is as much hard and detailed work as in a well conducted quantitative study! However, when students are asked to reflect on their assumptions about qualitative methodologies, it is often the case that qualitative epistemology resonates with them as having a good 'fit' with their clinical experiences and their own narratives of encounters with patients (Elwyn, 1996). HCPs from a general practice or primary healthcare background are often intrigued and excited when they realise that it is possible to analyse, in a rigorous and systematic manner, transcripts from in-depth interviews using a qualitative method such as IPA.

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The IPA website can be accessed at: http://www.psyc.bbk.ac.uk/ipa

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