“Researcher Saturation”: The Impact of Data Triangulation and Intensive-Research Practices on the Researcher and Qualitative Research Process

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Theoretically and methodologically sound qualitative research demands an extended period of fieldwork and the use of multiple methods to achieve data saturation and develop the grounded theory. Little is known about the experiences of researchers who conduct such studies. The authors explore these matters by drawing on their experiences of conducting a 3-year qualitative study with women about their gynecological cancer journey. Their fieldwork consisted of participant observation and in-depth interviews with women and health professionals. They demonstrate that researchers who are involved in all phases of emotionally demanding research; that is, data collection (recruiting, observing, expanding field notes, and interviewing), transcription, and data analysis repeatedly relive difficult events, which might potentially compromise the researchers’ well-being and, in turn, the research process and data validity. The authors discuss how researchers can deal effectively with these matters during fieldwork and propose a more formal approach to debriefing.

Keywords: sensitive research; saturation; multiple methods; longitudinal

Studies indicate that qualitative research is a useful means of collecting sensitive data and understanding emic perspectives. It is argued that this type of research is cathartic for study participants (Gale, 1992; Ortiz, 2001), particularly those involved in longitudinal research (Grinyer, 2004), but what is the experience of researchers who encounter stressful and traumatic events during this type of fieldwork? Cowles (1988), for example, argued that “observing frequent intense emotional responses of others, [and] very personal activities or violent behaviors can be psychologically and emotionally wrenching for investigators regardless of how experienced they are in conducting research” (p. 173).

Indeed, in response to conducting in-depth interviews on topics such as childhood sexual abuse, domestic violence, homicide, rape, bereavement, and suicide, researchers reported gastrointestinal problems, vomiting, nightmares, insomnia, headaches, exhaustion, and depression (Alexander et al., 1989; Cowles, 1988; Dunn, 1991; Etherington, 1996; Hunt, 1989; Ridge, Hee, & Aroni, 1999; Sullivan, 1998).

Despite reflexive writing on these negative experiences, little is known about their implications on the research process and data validity. Most researchers fear disapproval from colleagues and worry whether their objectivity will be questioned (Lee, 1995), which leads to poor discussion of these matters. Hunt (1989), in a rare example of discussing the relationship between fieldwork and data validity, explained her difficulties in remembering the details of a police rescue of a woman who was stuck under the wheels of a bus; the trauma the researcher suffered ultimately resulted in a distorted account. In contrast, Ridge and colleagues (1999) have discussed how researchers might use their emotional reactions to fieldwork data as an analytical tool. For

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example, an ethnographer who interviewed outreach workers and clients about self-harm and suicide resumed smoking during fieldwork. Smoking, which had in the past been used by the researcher to self-soothe, helped the research team to understand the “link between emotional trauma and self-harming behavior” (p. 26). Although this resumption of smoking also compromised the researcher’s health, the authors do not elaborate on this matter. In addition to interviews, the second phase of qualitative data collection, transcribing, is also potentially problematic. Verbatim transcriptions require repeated listening and reviewing of the entire transcripts to ensure accuracy. Consequently, this process repeatedly exposes the (professional) transcriber to emotionally distressing accounts on tape (Gregory, Russell, & Phillips, 1997; Morrell-Bellai, Goering, & Boydell, 1997).

In this article, we extend the discussion of the problems of qualitative researcher distress and explore the involvement of researchers in all phases of research—data collection, transcribing, and data analysis—particularly given that the last has not been addressed extensively in the literature. This issue is important as theoretically and methodologically sound qualitative research requires an extended period of fieldwork and the use of multiple methods, such as interviewing and participant observation (Rice & Ezzy, 1999). Although adhering to these principles is important to achieve data saturation and the development of grounded theory, repeatedly reliving difficult events might compromise the researchers’ well-being and, in turn, the research process. Various strategies can be employed by researchers to prevent researcher burnout and ensure data validity. To illustrate these matters, we use our experience in conducting research with women diagnosed with gynecological cancers.

In Australia (and internationally), gynecological cancers are relatively rare but are nevertheless among the top 10 cancers with which women are diagnosed (Australian Government, 2004). In Australia, 1 in 11 women has a lifetime risk of being diagnosed with breast cancer (Australian Government, 2004). One in 34 women is at risk of developing a gynecological cancer by the age of 75, with significant differences according to type of cancer: 1 in 75, 101, 201, and 569 have a risk of developing endometrial, ovarian, cervical, and vaginal, and vulval cancers, respectively (Australian Government, 2006). The 5-year survival rate depends on the type of cancer and is low for women with ovarian cancer (42%) but about the same for women with cervical (75%) and endometrial cancer (81%) as for women with breast cancer (84%) (Australian Government, 2006). Screening programs for early detection of ovarian cancer are not available, and hence most women (75%) are diagnosed only after considerable delay, when the disease is advanced, because of subtle and confusing symptoms; hence the term “silent killer” (Dillon, 1994). Limited research, predominantly quantitative, had been conducted on the psychosocial impact of gynecological cancer on women but does not report on the impact of this research on the researcher (Auchincloss, 1995; Cochran, Hacker, Wellsich, & Berek, 1987; Corney, Everett, Howells, & Crowther, 1992; Eisemann & Lalos, 1999; Lamb, 1990; Roberts, Rossetti, Cone, & Cavanagh, 1992). Similarly, qualitative research (including our own) has discussed the “cancer journey” from the gynecological cancer patients’ perspective (Ferrell, Smith, Ervin, Itano, & Melancon, 2003; Fitch, Deane, Howell, & Gray, 2002; Howell, Fitch, & Deane, 2003a, 2003b; Manderson, Markovic, & Quinn, 2005; Markovic, Manderson, & Quinn, 2004, 2006; Markovic, Manderson, Wray, & Quinn, 2004, 2006; Moore Schaefer, Crago Ladd, Lammers, & Echenberg, 1999; Wray, Markovic, & Manderson, 2007) but is devoid of methodological discussions on the researchers’ “journey” in this process.

What makes this journey unique is that the topic of investigation is cancer, a disease still commonly feared by the public (of which researchers are not exempt!) (Johnson & Clarke, 2003). Second, when researchers are of the same gender as the study participants, this might enhance empathetic rapport (Manderson, Bennett, & Andajani-Sutjahjo, 2006), but it might also raise anxiety in the researchers because as women they, too, could be afflicted with the same illness. Third, in response to being immersed spatially and emotionally in stories of women with gynecological cancer who are dealing with frightening emotional and existential pain, there is the potential for researchers to be affected by countertransference (the subconscious transfer of experience of the study participant/patient to the researcher) (Halbrook & Ginsberg, 1997).

Method

In this study, we applied a qualitative approach, suitable to explore the meanings that people attribute to particular life events, including health and illness (Manderson, Markovic, et al., 2005; Markovic, Manderson, & Quinn, 2004, 2006; Markovic, Manderson, Wray, et al., 2004, 2006; Wray et al., 2007). The approach was based on
grounded theory (Strauss & Corbin, 1990), whereby data informed a theory of women’s experiences of gynecological cancer, including their ability to draw on the wider cancer discourse and access social support. Our data collection phase started with participant observation. Subsequently, in-depth interviews were conducted with women who received treatment in tertiary teaching hospitals providing gynecologic oncology care. Generally women were interviewed shortly after diagnosis, on completion of treatment, and then 8 to 12 months following the first interview, or only once in cases when they had been diagnosed between 12 months and 5 years before we met. Low presentation of cases in the study hospitals during the period of recruitment of participants and overall very low incidence of some gynecological cancers among women influenced this approach. The study sample, recruited between January 2001 and December 2003, included in total 52 women aged 27 to 80. Most had ovarian (21) or endometrial (18) cancer, although a few had cervical (7), vaginal, or vulval (6) cancer. With these women a total of 77 interviews were conducted, which included 52 first interviews and 25 follow-up interviews.

The study was approved by the university and hospital ethics committees. Patients were recruited while they were inpatients or in the waiting area of an outpatient clinic that they attended for their follow-up appointments. Each woman was provided with a participant information statement that outlined the aims and objectives of the project and the details of her involvement, that is, in-depth interview. Women were invited to seek additional information from the researchers, and once the woman agreed to participate, an appointment was scheduled for an interview; a signed consent was obtained prior to commencing it. Interviews were open ended and narrative in style, with the interviewer initially simply inviting each woman to tell her story of being diagnosed with and treated for gynecological cancer. The flow of information was determined by individual study participants, although, when necessary, interviewers sought clarifications or elicited additional information. This interviewing technique ensured that study participants spoke about issues pertinent to their experience of illness and helped achieve data saturation. On average, interviews lasted between 60 and 90 minutes. All interviews were taped and conducted either at participants’ homes or at another place of their choice. Subsequently, interviews were transcribed by the researchers.

We commenced research by conducting participant observation at the study hospital. This included observing clinical consultations at an outpatient clinic, chemotherapy room, and gynecologic oncology ward. We also attended various workshops for gynecological cancer patients held at the hospital and ventured out of the clinical setting and into the community. We observed (and remain involved in) one formal cancer support group and cancer programs and workshops as well as attended memorial services and funerals of our study participants; four of our participants died during our fieldwork.

Data collection and preliminary data analysis were conducted concurrently, allowing us to cease recruitment on achieving data saturation and to modify interview guidelines for subsequent in-depth interviews to incorporate emerging themes. Nevertheless, as we will discuss, data analysis continued after data collection finished. Atlas-ti software was used to perform thematic analysis. We identified salient themes in individual transcripts and searched for repetitions within and across narratives and field notes (Ryan & Bernard, 2003). In the presentation of the data below, we discuss the impact of the fieldwork on the researchers and the research process.

Results

Intensive Research Methods

The outpatient and chemotherapy departments operated only on 1 day of the week. This led to our recruiting patients, collecting participant observation data, and maintaining rapport with study participants and health professionals through informal conversations on the same day, all of which were the tasks of the first two authors. Participant observation of the chemotherapy room would last for about 3 hours in the morning and was followed by our attending a 1-hour meeting of the oncology team at which patient histories and plans of treatment were discussed. The afternoon was again dedicated to participant observation at an outpatient clinic and doctors’ consultation rooms for about 3 hours. We would finish the day by writing up our field notes arising from participant observation and informal interviews.

Recruitment was determined by the presentation of cases to the study hospital and was slow. We felt compelled to be present each week throughout the data collection phase so that we would not miss potential participants or fail to observe the practices of individual clinicians. Every week was associated with some form of distress: witnessing women diagnosed belatedly (mainly because GP referral was inadequate) (Markovic, Manderson, & Quinn, 2004), women believing that their enlarged abdomen indicated pregnancy rather than tumor
growth, and women’s bodies no longer responding to clinical treatment. Midway through our research the intensity of conducting concentrated participant observation started having an impact on the physical and emotional health, particularly of the first two authors, as seen from the following excerpt:

[(Day of the week, in anticipation of fieldwork] started off being an awful day for me. I woke up at 6.30 am and immediately started crying as if I knew what was going to follow. Later that day at the outpatient’s department a gynecologic oncologist told the patient that no treatment can cure her. . . . A daughter and son hugged their mother and cried. . . . I just sat there. . . . I felt helpless. . . . The crying and tears went on for about 10 minutes but it felt longer. My eyes welled up and I held back the tears. A lump was in my throat. . . .

When I walked back to the office after the clinic I felt sick, heavy and was dragging my feet. . . . I felt so tired. I want to go home. I find being at the hospital so tiring and I feel emotionally drained when I’ve finished. I’ve written some field notes and I can add to them tomorrow but now I think I want to go home. I’ve had enough for today. . . . I’m still writing notes which are nearly one month old. (field notes)

Hence, although intensive participant observation allowed for a better understanding of the emic perspectives of women, the distress we experienced affected our ability to expand all field notes. At times, we delayed expanding field notes in response to feeling fatigued and unwell, which possibly resulted in relapsed memory. However, we always expanded those notes that referred to new emerging themes and were pertinent to women’s experience. Second, as two researchers were involved in participant observation and were very rarelyfatigued at the same time, triangulation of their two different data sets contributed to verifying data validity. Third, as the purpose of the written notes was to provide a contextual background to women’s narratives and inform interview guidelines, bias implications were minimal.

Once a month this intense day of participant observation was followed by the first two authors’ attending a gynecological cancer support group held in the evenings. Although interviewing in the evening is not recommended and can increase researcher fatigue (Cowles, 1988), participant observation cannot be scheduled in the same manner. The support group commonly started with each woman lighting a candle to remember those patients who had died. This was particularly hard for us when the deceased were also our study participants. Women in the midst of their treatment also attended the support group, and as a result of side effects of adjuvant treatments were frail and weak and sometimes in wheelchairs. At times, when these members did not attend meetings, we had a lingering doubt in our mind about whether this was because their health had deteriorated so much that they had become incapacitated to leave the house or whether the reason was more distressing: a death about which we had not yet learned. On other occasions, we knew first that a patient had died. Although we did not volunteer this information, when we were asked, we felt distressed that we were the ones who had to pass on the bad news. In the event of a support group member’s death, we also had to comfort group members, especially those women who had experienced a relapse. At these times, we felt that we had to withhold our feelings to not add to their distress.

Other intermittent encounters with patients and their family members, such as attending a 10-week Living with Cancer Program, a 6-week alternative healing cancer program, a 1-day Looking Good, Feeling Better workshop, or attending funerals and memorial services for cancer patients, led us to feel that the research was a never-ending continuum, blurring boundaries between research and everyday life. We describe this below.

**Blurred Boundaries**

Finishing participant observation for the day did not provide sufficient reprieve from feeling inundated with researching women’s experiences of gynecological cancer. We returned home with images of women being told of their illness or prognosis, being hooked up to intravenous (IV) machines, distressed patients, and family members walking down the corridors or seeing saddened doctors as they exhausted all treatment plans without success. We were also constantly reminded of the multiple disadvantages faced by women (cf. Dunn, 1991), that is, the futility of medical treatment and/or health inequities that compromised their health outcomes, as recorded in our field notes:

[Ovarian cancer patient] was diagnosed with brain cancer for the second time within 6 months of her surgery. . . . She was distressed by the ineffectiveness of the first treatment but also by financial implications of the recurrence and a doubt if she could raise the money again. . . . I felt really awful when I got home from the hospital. Everyone I met today is sick and I felt miserable about the unfairness of it all. (field notes)
These visual and embodied memories were supplemented by the memories of sounds, such as beeping machines, patients sobbing, and meals being wheeled into patients’ rooms, and the smells of antiseptic, drugs, and food, which permeated the ward. All of these sensory memories found their way into our subconsciousness through dreams—nightmares—that continued our constant exposure to research. One of the researchers recorded this in her field notes:

I had a busy day interviewing, observing and then attended a support group meeting in the evening. I fell into bed, desperate to fall asleep and forget about the day. Women’s words were zipping through my mind and I could picture one of our study participants, hand and wrists dotted with pinpricks from several courses of chemotherapy, as she had shown me earlier that evening. After some time I fell asleep but only to find myself dreaming that I too was being forced to have chemotherapy. I could see the nurse putting the drip in my hand, but it felt as if she was puncturing my hand, arms, and my entire body. (field notes)

Even on those occasions when participant observation in the chemotherapy room and outpatients’ department was not as intensive, the distress witnessed on other days remained with us. Embodied distress we felt during conducting fieldwork in the hospital site was further compounded by the close proximity of the hospital to our office. We felt we were continually in the thick of it (cf. Gair, 2002), much like our study participants:

When [approaching the hospital for follow-up appointments] the building looms up, I just want to run away. . . . I want to run away because it reminds you that you’ve had cancer, it may come back [you need to be under surveillance].

Our response to participant observation mirrored the experience of our participants, as reported elsewhere (Rothman, 1986). The application of data triangulation (i.e., interviews) to increase the validity of our qualitative research (Rice & Ezzy, 1999) had further implications for the researchers, as we discuss below.

**Researcher Saturation**

During interviewing, we asked women to reflect on all aspects of their illness. They shared their experiences with us, and interviews clearly had a cathartic value for them. However, at times, we found listening to (or reading) women’s accounts difficult, particularly when they described the unpleasantness of intimate examinations:

He [the gynecologic oncologist] examined me and the next thing I knew, was that he had thrust his hand up my vagina and also up my rectum. . . . It just felt like an invasion, you know, it was embarrassing. . . . I feel like you’re just a piece of meat.

Following interviews and observations, we relived women’s and our own negative experiences through transcribing and expanding field notes, as illustrated below:

The worst incident of the day was when a woman entered the consulting room. She looked anxious and her breathing was shallow and short. The gynecologic oncologist started to read through her whole medical history and I could see her getting more anxious. She rested her elbow on the table and lifted her hand to her forehead in order to hold her head up. During the physical examination I could hear her breathing and it was getting louder. I did not hear the gynecologic oncologist’s attempt to calm her. Instead he said, “I know this hurts” a few times and I felt terrible for her. (field notes)

We were unable to have breaks during fieldwork, as recommended when conducting ethnographic research (Cowles, 1988; Sterk, 2000), because we were simultaneously recruiting, observing, writing up field notes, interviewing, and transcribing; funding support was also time limited. We felt that if we followed this advice, we would compromise research continuity and patient recruitment. This burden of multiple methods and longitudinal research contributed to researcher saturation with the data. 10 months into our fieldwork, it felt as if we had conducted 40 interviews, even though the number was half that. However, we were conscious that we had not reached data saturation and needed to continue to recruit, organize new interviews, and maintain contact with those already involved in the study. One of the researchers’ field notes read,

I am quite overwhelmed because I need to do another 20 follow-up interviews. That means two interviews per week to finish by May. Hell. (field notes)

Consequently, organizing interviews with participants was problematic because it was physically difficult to pick up the telephone (cf. Johnson & Clarke, 2003). Nevertheless, we stoically continued conducting participant observation and interviewing, but when we
returned to the office, we did not want to rewitness these experiences through expanding field notes, as suggested earlier:

I’m still writing notes which are nearly one month old. . . . I’m actually finding writing field notes getting more difficult. At the beginning I would write lots of notes down and then run to my computer and type them up before going home. Now I jot them down in my notebook but I haven’t written up my notes in long-hand, as I’ve said, for a long time. I guess emotionally I’m getting more involved. I’m also getting tired of cancer. (field notes)

As suggested in the introduction, transcribing was also difficult as we were relistening to the suffering of research participants; we did not have the luxury to pay for professional transcribers. Distress has been reported by those involved in transcribing multiple interviews with the same participant (Gregory et al., 1997; Morrell-Bellai et al., 1997). Over time they felt as if they formed an attachment; we felt the same because we conducted up to three interviews with the same participants, met them at support group meetings, and kept them company in the chemotherapy room or on the ward. Revising transcribed data is on its own difficult because it involves ongoing exposure to participants; those researchers involved in all stages—interviewing, transcribing, and data analysis—are additionally exposed (cf. Dunn, 1991). We experienced researcher saturation—more commonly referred to as burnout—and gradually emotional overload led to our experience of distress: frequent headaches, anxiety and panic, a “foggy head,” dizziness, nausea, and even a cyst on the vulva, reinforcing the embodied experience; exposure to fieldwork and personal life experience mediated individual responses of researchers. Like our study participants and others narrating a chaotic story about their illness experiences (Frank, 1995), we felt entrapped in a chaotic body; we did not want to analyze in great depth or write about what we had learned, which occasionally caused friction among team members. We felt like Fanny Burney in her personal account of breast cancer: “I dare not review, nor read [her diary], the recollection is still so painful” (cited in Kaye, 1997, p. 613).

To minimize the impact of researcher burnout on data validity, following each interview, the research team conducted preliminary analysis to identify emerging themes to be explored further in subsequent interviews. The involvement of several researchers in this process ensured that cross-checking of emerging themes identified by individual researchers contributed to data validity. Our second strategy in relation to a delayed in-depth data analysis was to continue recruitment and interviewing until collaborative data analysis, which in addition to themes, identified the patterns in women’s experiences and demonstrated data saturation, that is, that no new themes, were emerging. As explained in the methods section, our style of interviewing also ensured that women had the freedom to share with us their stories without any limitations to the breadth and depth of information. Third, in the final stages of our research, we limited participant observation to the study hospital only, which reduced researcher distress and allowed more time for researcher recuperation and, in turn, in-depth data analysis. Fourth, as we developed an ongoing rapport with women, we were able to maintain relationships with them outside the hospital setting and thus reduce our exposure to multiple unpleasant events in the ward and outpatient clinic.

Responding to the Needs of Women

In the second year of our fieldwork, we were increasingly unable to separate ourselves from the research not only because of continuing data collection but because we were responding to the needs of women. Our study participants talked with us about the most frightening existential and personal crises, and our interactions changing as their disease took unpredicted paths. Researchers (Ellingson, 1998; Scheper-Hughes, 1992) noted multiple identities of researchers during fieldwork. Like women diagnosed with gynecological cancer, who were undergoing a period of rapid transition from the kingdom of the well to the kingdom of the sick (Sontag, 1978), we, too, were engaged in transition. Our identity moved from that of a researcher to an advocate to a friend; Oakley (1981) described this relationship change as the “transition of friendship” (p. 44), as discussed further below.

Women let us into their intimate lives and trusted us at a time when they were most vulnerable, and, in turn, we reciprocated as best we could. We supported some women by accompanying them to or from support group meetings. Other women telephoned us at home or at work to chat, and we listened while they aired some of their concerns and frustrations. We comforted women when they were alone when diagnosed with cancer. We felt empathy toward women and wanted to give them something in return for their time. We did not do that only because it was our duty
as per human research ethics guidelines but also because we identified with the women. As women, we could relate to women’s distress about their diagnosis and embarrassment of “under the knickers” examinations, as previously discussed. Some women were the same age as the researchers or our close relatives, making it easy to establish rapport and enhance mutual understanding of issues surrounding this illness. Although we were placed in a privileged position as we held knowledge of the evidence-based management of gynecological cancer, we were often caught in a complicated web, trying to negotiate what women told us and what we knew. For example, some women in the study hospital were not advised to use vaginal dilators to prevent the formation of adhesions following radiotherapy. This was against evidence-based medicine, which demonstrates a better outcome for women who used the dilator correctly versus other women (Decruze, Guthrie, & Magnani, 1999). However, we did not have the authority, nor could we not raise the issue of vaginal dilators with the women, as we did not want to alarm them. We sought an alternative way to give information to women by drawing this practice to the attention of the head of the department where the study was conducted, who discussed this with colleagues, who, in turn, subsequently changed their practice.

This was not the only occasion when we interfered. For example, some study participants incurred financial costs in the course of their illness. One participant, a welfare recipient, was involved in a car accident on her way home from a hospital appointment when she unexpectedly learned that she had cancer. She had to pay $400 excess on her car insurance, followed by being required to pay for radiotherapy treatment. She explained to us,

> It doesn’t sound much [$320] to most people but... for someone who lives in a housing commission flat and you’re on a pension, that’s hard to come by. I missed my follow-up appointment with my radiation oncologist because I could not pay the full amount but rather in several installments.

We were distressed to learn of the financial problems that patients incurred. We felt compelled to improve their situation, especially when we knew that women were having garage sales and borrowing money to finance treatment and associated costs. We aimed to assist study participants to be aware of the fact that referral to a private hospital meant that they had to pay for treatment but that public hospitals provided the same treatment, albeit perhaps not in as timely a fashion. To do so, we negotiated with hospital authorities that women receive information on the differences between public and private treatment facilities; many women were unaware that they would incur costs at private treatment centers. Our intervention led to health professionals’ explaining to women the advantages and disadvantages of having adjuvant treatment at various facilities and, in most cases, directing women to public treatment facilities in the first instance.

We felt that by changing the treatment options health professionals discussed with women, we were helping women in informed decision making. The bias we created—improving informed consent to treatment—was not substantial and did not compromise data validity. This is because once the practice was identified and recorded, and given that qualitative research does not aim for generalization (Rice & Ezzy, 1999), this practice became dispensable. Furthermore, as the aim of our project was to improve quality of care, we wanted to fast-track changes to practice rather than wait until the project was completed. Consistent with qualitative research, which is concerned with identifying the emic voice, our intervention allowed us to raise the concerns of our study participants as soon as they were identified (cf. White & Verhoef, 2005). This approach was also guided by the principles of participatory action research, which aims to empower study participants in their decision making, including being able to maintain and improve their health (Rice & Ezzy, 1999; Williams, 1999). Finally, although we were concerned that we might be criticized about biasing data, with this approach we also adhered to the ethical principle of not harming the study participants by withholding knowledge of relevance for women’s health care.

Ethics applications require researchers to speak about the direct or indirect value of research. Our research was designed to help health professionals to understand and respond better to the needs of women with gynecological cancer. For many patients, however, the research that they needed most was clinical, leading to improving survival rates. Our research could not offer that, but women volunteered to speak with us as for many this was their only opportunity to share their experiences. We valued the cathartic aspect of our study for women and saw the value in publishing our research to advance theoretical discussions on living with a life-threatening illness. Although we knew that study participants in women-centered research value storytelling as a means of learning other women’s stories, which might reduce feelings of marginalization (Warren, Markovic, & Manderson,
2006), at times, we also felt helpless that the benefits of our research were limited to storytelling rather than survival.

Closeness and Distance

Even though intellectually we knew that researcher distress is a part of qualitative research, during our fieldwork we found ourselves, like the women in our study, in a “period of confusion—without ground rules and without a clear way to escape the mess” (Merry, 1985, p. 6). We became vulnerable observers (Behar, 1996). Peer discussion, debriefing, and the consideration of boundary management strategies are recommended self-care strategies for qualitative researchers (Dickson-Swift, James, Kippen, & Liamputtong, 2006; Pickett, Brennan, Greenberg, Licht, & Worrell, 1994; Wincup, 2001), as are stress management techniques (social events, hobbies, travel, and exercise) (Rager, 2005). As researchers, we wondered about how to remain connected to our data and our study participants without living in a fused state, a dilemma for all researchers. Initially we drew on stress management strategies, such as talking with each other and close friends, meditation, and physical exercise such as walking. Even ordinary daily tasks had a therapeutic value. An excerpt from one of the researcher’s field notes reads, “I have a shower to wash away the day. I feel better but it [negative feelings] stays with me” (field notes).

These simple strategies to improve our physical and emotional health did not work for all team members, particularly junior researchers. Hence, one of the researchers episodically scheduled some sessions with the university counselor to debrief, as recommended after emotionally distressing interviews (cf. Urquiza, Wyatt, & Goodlin-Jones, 1997) and for researchers suffering from compassion stress (cf. Rager, 2005). Discussing with the counselor women’s stories of gynecological cancer enhanced the quality of the data because it provided insight into the pervasive emotions associated with the study participants’ cancer journey and also revealed the researcher’s own deeper issues (cf. Rennie, 1994). However, the few sessions free of charge, to which the researcher was entitled, did not alleviate the now-embodied distress. Consequently, she continued this emotion work with a fee-for-service psychotherapist, a strategy not easily employed by all researchers. There were, in addition, compounding effects: Other responsibilities and duties, professional and personal, became more difficult as our efficiency and focus faded as a direct result of our distress and anxiety, and we became increasingly unable to support each other as we struggled to get through days of incomplete activities and other mounting demands.

Discussion

Our qualitative research with women diagnosed and treated for gynecological cancers in some ways resembled the experiences of researchers involved in conventional ethnography or in participatory action research, in which the researcher works intensely and in partnership with the study participants to achieve a common goal (Rice & Ezzy, 1999; Williams, 1999). In contrast to other research methods that offer little opportunity for building and sustaining relationships between the researchers and the study participants, such as a rapid needs assessment or quick ethnography (Beebe, 2001; Handwerker, 2001), the longitudinal nature of our research resulted in the development of an intense relationship with participants. The creation of this relationship was informed by the principles of qualitative research, which foster reciprocity between the researcher and the study participants (Harrison, MacGibbon, & Morton, 2001). In return for sharing their stories of distress with us, we took the necessary steps to ease women's emotional concerns and empower them but also, in return, minimize our distress in response to learning about women's disadvantages. Our listening skills, the provision of information about available support services, and the change that we initiated in relation to doctor–patient communication regarding treatment options were all part of our reciprocal relationship with the women.

Although we were not unprepared for researching women’s experiences of gynecological cancer, we were disadvantaged in this study for several reasons. First, the research team lacked personal life experience with cancer, and we were placed on a steep learning curve (of oncology, gynecology, and psychology) while we struggled against vicarious unpleasant voyeurism. This contrasted with Ellingson (1998) and Stacey (1997), who as cancer patients themselves explored the experience of cancer patients. Second, the alternative means of learning about women’s experiences of gynecological cancer and drawing implications for researchers were also limited. As we led the pioneering work on qualitative research on gynecological cancer in Australia, scarcity of qualitative research on gynecological cancer and lack of discussion of the researcher’s journey, as discussed in the introduction, inhibited our emotional
preparation for our fieldwork. Media reports on celebrities with this type of cancer or personal stories of ordinary women are rare (Wray et al., 2007); the only available study at the time of our research, which focused on women’s cancer stories in Anglophone Australian women’s magazines, focused on breast cancer (McKay & Bonner, 1999). Although two of us had experience in conducting research on sensitive topics (e.g. terminal illness, death, and dying) and the research team had engaged with the relevant literature (see Gilbert, 2001), the contextual difference and lack of reports on fieldwork difficulties and data analysis remained. The availability of such information might have sensitized us more, although it would have never fully prepared us for the experiential learning experience.

Our study advances our understanding of the implications of researcher-related stress for the researcher’s well-being as well as data validity, in particular for researchers involved in all phases of longitudinal, multiple-methods, and emotionally demanding qualitative research. This article demonstrates the importance of systematic teaching of qualitative researchers about these issues, which is rarely reported as praxis. This contrasts with professional development for workers who might be exposed to similar distress. For example, hospice volunteers, who provide companionship for dying patients, are trained to be conscious of “how they feel” and discuss their negative feelings with other volunteers (Fox, 2006, p. 953). Although the journey of hospice volunteers includes developing friendships, sharing sadness and tears, and attending funeral and memorial services, which mirror our cancer journey, we had to learn how to develop these skills and manage these matters “on the job.”

Second, the principles of data saturation as applied in health research might need to be reconsidered. Qualitative research talks about data saturation; that is, stopping data collection once new information is no longer identified and when only repetitions are noted. Although qualitative studies generally involve between 30 and 60 participants (Morse, 2000), Guest, Bunce, and Johnson (2006) conducted 60 in-depth interviews with women in two west African countries but maintained that they reached data saturation after they conducted 12 interviews. On the other hand, to the extent that each life they reached data saturation after they conducted 12 interviews. On the other hand, to the extent that each life

or judged against the norms of quantitative research, and specifying numbers can be misleading and inappropriate; researchers might also increase the number of data participants when they use qualitative data software. In addition, depending on the research topic and its aims and objectives, when participant observation is conducted to gain contextual information to shape interview guidelines and assist our understanding of accounts, it might be sufficient to limit this to the first phase of fieldwork. This also ensures that researchers are not “drowning in data” (cf. Morse, 1993), another contributor to researcher saturation.

Our final argument relates to debriefing. Currently the main forum for discussing the emotional impact of qualitative research is within the research team. Scott (1996) has suggested that supervision and/or a reference group is useful for debriefing and dealing with unanticipated emotional responses to the research. In contrast, we found that debriefing within these forums was not sufficient for all researchers. In light of our experience, we strongly encourage research institutions to consider making professional counseling available to researchers, an area worthy of further research, especially as it was recently recommended in the Australian National Statement on Ethical Conduct in Human Research that qualitative researchers involved in sensitive and emotionally demanding research should have sufficient training and clear protocols for dealing with researcher distress (Australian Government, 2007).

Notes

1. All subsequent discussion refers to research discussed in these articles.
2. Private health insurance only partially covered the cost of the first operation, which she opted to have in a private hospital to avoid being on a public hospital waiting list.
3. The National and Health Medical Research Council’s National Statement on Ethical Conduct in Research Involving Humans Section 1.3 states, “In research involving humans, the ethical principle of beneficence is expressed in researchers’ responsibility to minimize risks of harm or discomfort to participants in research projects” (Australian Government, 1999, p. 11).

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