Coming to Autoethnography: A Mental Health Nurse's Experience

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In this article, the authors outline how a doctoral student came to use autoethnography within a narrative inquiry study exploring the experiences of being an adult child of a parent with a psychosis. Throughout the article, they discuss the researcher's experiences and identify techniques they found useful in preparing for the present research process. As a qualitative research method, autoethnography is useful for making connections between researcher and participant, deepening interpretive analysis of both common and differing experiences, and producing knowledge drawn from compassionate understanding and rigorous reflection.

Keywords: *reflexivity, autoethnography, self as research tool, evocative writing, adult children of parents with a psychosis*

Introduction

I'm sitting in my office at work, having received a letter from Margaret, my doctoral supervisor. We've been talking about writing a journal article on autoethnography, and as a way to start structuring the article, she writes, "As you might lack confidence and experience in beginning such a paper, a challenge might be in order. So, here it is! Perhaps by answering these questions . . . we might have the substance for a very good paper—useful for other qualitative researchers considering the method."

I look at the long list of questions and silently agree that they are, indeed, a challenge. I feel a bit overwhelmed, do not know where to start, and do not think I know the answers to many of them at this point, but I can see that it is going to be interesting trying to find out. It is exciting to think that the process of addressing these questions should lead to a greater understanding of what I have known intuitively to be the appropriate method to foreground my research but have not as yet been able to articulate fully and substantiate in a scholarly sense.

I find myself wearing two hats, neither of which seems to fit well just yet. I am the adult child of a parent with psychosis, and I am also a doctoral student trying to make sense of a long and challenging note from my supervisor.

The note read,

- *How does your life experience shape the theory that will frame your method?*
- *What "cultural baggage" do you bring to the research encounter?*
- *How might this research endeavor be emancipatory/transformative for you?*
- *What issues do you think may prompt you to "re-identify" as an adult child of a parent with a psychosis?*
- *What issues are likely to be strange/familiar for you when you encounter the research participants?*
- *How will your identity place limitations on the research?*
- *How will your identity offer opportunities, insights, innovations for the research? And for the readers of your research?*
- *In what ways does this raised awareness of your identity help to bring into focus the relationship between the researcher and the researched?*
- *What questions will you be expected to "know better than to ask" these research participants?*
- *What kinds of access might it give you because you share the identity of the participants? What might participants say to you, that they might not say to another?*
- *How do people react to you when you declare/have declared this identity?*

In this article, we will outline some answers to these questions by explaining the interpretive method of autoethnography. Personal experience is interwoven with scholarly comment and used to explain how a doctoral research project developed. The authors, one a doctoral student and the other two research supervisors, explore the use of autoethnography as a method in qualitative research and discuss the challenges and opportunities it raises for qualitative researchers.

Reflecting on the experiences of being the adult child of a parent with a psychosis

My experiences as a child and adult child of a mother with schizophrenia have been profound and life shaping. They are not experiences that can or should be simply bracketed, but neither should they overshadow the experiences of others. As revealed here, they are multifaceted and reflect the multiple identities we can each develop in everyday life.

My personal story started many years ago, when I was born the eldest daughter of a mother who eventually developed a severe paranoid psychosis. I subsequently spent much of my childhood being raised in various welfare institutions because of my parents' marriage breakdown and the deterioration of my mother's mental health. Her illness and my experiences of being raised in institutional environ-

ments became so intertwined that when I think back to those years, the two issues are inevitably bound up with each other. I was left as an adult with a number of emotional issues and difficulties resulting from my childhood, and spent some years working at both a personal and professional level to come to terms with some very unhappy childhood experiences. Until I had counseling to address these, my feelings of shame, sadness, guilt, and anger had left me struggling to find much good to say about my childhood.

I particularly struggled with developing a good level of self-esteem and a firm sense of self-worth. My experiences as a "homekid" living in welfare institutions had left me with a sense of being different and "second best." During childhood, I also established such rigid emotional boundaries to protect myself from hurt that as an adult I found it difficult to allow others to be emotionally close. Alongside this, I developed intellectualization as a defense against feeling past pain and was only slowly over a long period able to allow the intense emotions I held so closely to emerge. Out of this, I also struggled to come to terms with anger toward my mother, my father and other family members, and my circumstances. I have also worked at managing general anxiety and a sense of insecurity. Even now, I find it difficult to share these previously hidden and shameful feelings with others.

Becoming a psychiatric mental health nurse: Respecting difference

My professional story began in the late 1970s, when, having chosen nursing as my career, I completed my general nursing hospital training and then moved into psychiatric mental health nursing, where I worked first as a psychiatric nurse clinician and then as clinical educator and university lecturer in psychiatric mental health nursing. I have often questioned why I went into this area of nursing. One of the primary reasons, I think, is that it enabled me to understand the notion of mental illness. It also gave me a sense of control and personal power. The sense of control was in knowing what mental illness was and how to manage and treat it, as well in terms of distance; being able to see myself clearly as separate from the clients I nursed. I was not like them (or, therefore, my mother), not "mad," and, consequently, not at the direct mercy of such a seemingly unforgiving illness. For the child who had felt she had no control in terms of having a family life, a functional mother, and a sense of security and safety, it was very reassuring to feel I was firmly situated on the "other" side of the therapeutic fence. In a literal and metaphorical sense, I held the keys this time, not someone else. Although this notion was comforting, it also worried me, in that I was aware of the inherent tension in wanting personal control, on the one hand, in a professional setting where, on the other, I also needed to exercise appropriate professional caring for persons who had a mental illness, like my mother.

I was also attracted to psychiatric mental health nursing, as I saw it as affirming and respecting of difference. For most of my life, I had considered being different a social impediment and yearned to be just like everyone else—"normal," conventional even. In psychiatric mental health nursing, I found my home. I was just like everyone else (both clients and staff)—"different." I realized that my childhood experience of having a mother with mental illness and living in welfare institutions was such an unusual one in comparison to most other people in my social world that I had developed a great acceptance of, and, indeed, interest in, difference. I liked and enjoyed (and still do) quirkiness, eccentricity, bizarre behavior, and people whose beliefs, sexual preference, or unconventional thinking put them outside "the square" most people seemed to live in. To me, the psychiatric environment also valued and respected the person's subjective, intrapsychic experience, no matter how "different," and worked with the person to develop acceptance as well as change. I could at some level understand and empathize with clients' difference, and was able to offer acceptance and the willingness to work with them while also having hope for their future (and, perhaps, my mother's and my own). I also had a belated unwelcome but, nevertheless, strong realization that I was attracted to nursing at that time because it enabled me to continue living and working within an institutional environment.

From good idea to research project

My present research story started several years ago, when I began to think about the possibility of doing a doctorate and discussed the idea with some of my colleagues. I was sitting at my desk at work one afternoon, chatting on the phone with Mary, a friend and former colleague. "By the way, how's your mother going?" she says. "Oh, she's fine—doing well at the moment," I say. Then, with some indignation, I add,

> *I talked with her case manager recently—but, you know—all she wants to talk about is how I can help my mother! There's never any mention of how I'm going, or any recognition of how having a mother with paranoid schizophrenia might have affected me. It's always what I can do for her* [my mother].

Mary listened patiently to my complaint and then, in her familiar dry manner, responded, "Well, Kim, maybe there's a PhD in that." I was surprised and quite taken aback at her suggestion, as to that point, it had not even occurred to me to explore something as personal as my own experience.

Intrigued, I put down the phone and over the next few weeks began a review of the literature in the area of children of parents with mental illness (COPMI). I found that, indeed, there had been very little published research on the subjective experiences of either children or adult children of parents with a mental illness. There was plenty of empirical research on the issue of children of parents with mental illness, but little of it focused on diverse experiences, and only some focused on positive coping strategies and outcomes. It shored up my interest in and intention of pursuing this little-known territory, as it seemed there were a number of unanswered questions of the experiences of these children and adult children that were worthy of further investigation. During this process of discovery, in finding there was literature and research on an aspect of my life that I had previously borne in silence and largely alone, I felt a sense of wonder. I find it hard to describe the amazement that came with discovering that others actually knew about, and had acknowledged and validated through research, the impact of being the child of a parent with mental illness. I had not even been aware there was any recognition of the issue in the field of psychiatry. My growing awareness began to open up a new world of possibility for me, and, I started to think, perhaps for others.

Looking back, it was perhaps at this juncture where my personal story and professional story united and my experience, I realized, was probably not unique. There were possibly many people who had experienced chaotic, inconsistent childhoods disrupted by parental mental illness. Perhaps there were not many, however, who could or were willing to articulate the experience using dual identities of psychiatric mental health educator and grown child.

The present study

Empirical research and literature on children of parents with psychosis (e.g., Cowling, McGorry, & Hay, 1995; Rutter & Quinton, 1984) reveal they are more likely to suffer adverse psychosocial effects in both childhood and adulthood as a result of their background and experiences, but that this varies according to the presence of resilience (Luthar, Cicchetti, & Becker, 2000). There has been relatively little focus, however, on the diversity of adult children's subjective experiences of growing up with a parent with a mental illness, including psychosis, and how they have coped with the potentially adverse situations they might have encountered. Some studies (e.g., Camden Pratt, 2002; Caton, Cournos, Felis, & Wyatt, 1998; Dunn, 1993; Kinsella, Anderson, & Anderson, 1996; Lancaster, 1993; Stevenson, 2002) have explored adult children's experiences, although of these only Caton et al., Dunn, and Kinsella et al. have published their findings in journals. The others are unpublished masters' or doctoral theses.

The objectives of the current study are to explore some of the experiences of being an adult child of a parent with psychosis (ACOPP) and explore the ways that some adult children of parents with a psychosis have coped with these experiences. Nine participants with parents who have a psychotic mental illness, 7 women and 2 men ranging in age from 25 to 57 years, self-selected for the study after respond-

ing to word of mouth, radio interviews, and newspaper articles. The inclusion of the researcher's experience results in a total of 10 participants in the study, 8 women and 2 men. Narrative inquiry has been chosen to illuminate new dimensions to the issue of these adult children's experiences as we seek to understand participants' subjective experiences through focusing on the stories that structure and recall them. This serves to extend others' understanding of the impact of being an ACOPP by revealing the participants' lived experiences. Their personal interpretations of how these experiences might have affected their daily lives will be informed by a postmodern theoretical framework. Autoethnography is a method within this narrative inquiry that is being used to illustrate the researcher's use of self as the starting point for the study and for inclusion in field text analysis alongside the experiences of the participants.

Autoethnography is a research method that connects the researcher's personal self to the broader social and cultural context, whereby the researcher explores his or her own experiences to extend knowledge on the social issue in question. Autoethnography can be seen to range from starting research from one's own experience, to studies in which the researcher's experience is explored alongside those of the participants, through to stories in which the researcher's experiences of conducting the research become the actual focus of investigation (Ellis & Bochner, 2000). Although autoethnography as a research method is evident in disciplines such as ethnography, anthropology, education, communications, and from a feminist perspective, in terms of nursing research, it has not been embraced to its full potential. The published literature reveals comparatively little in the way of published material. Notable exceptions include work by Johnstone (1999), Muncey (2005), and White (2003). Chesney (2000, 2001) has also written on reflexive autobiography. Apart from Johnstone these writers are not, however, psychiatric mental health nurses, and from a psychiatric mental health nursing perspective, autoethnography can be considered an emergent research method (Foster, McAllister, & O'Brien, in press). In the following section, insider research is explained in terms of the current study and the first author's experiences of sharing her insider identity.

Being an insider and an outsider: The emic and the etic in nursing research

In "insider" research, originating in the field of anthropology, the researcher conducts research with a group of which he or she is a member and shares social and historical connections (Kanuha, 2000), such as in the current study, in which the researcher is also an adult child of a parent with a psychosis. Insider research, however, is distinct from that in which researchers "go native," or take on characteristics such as language, clothing, and other cultural practices of the people they are researching (Tedlock, 2000). Insider research, often used in ethnography, has also been conducted in other disciplines such as social work, feminist inquiry, and sociology (see, e.g., Coffey, 1999; Ellingson, 1998; Kanuha, 2000). Ellingson, for example, who previously had cancer, interviewed other patients with cancer.

Insider research is considered to be from an emic perspective, as it involves the description of a phenomenon that is understood by the researcher who has also experienced it (Spiers, 2000). In nursing, insider research has generally focused on the researcher's exploration of nursing practices, whereby they conducted research in a field of nursing in which they already worked or about which they were knowledgeable (see, e.g., Allen, 2004; Bonner & Tolhurst, 2002; Hewitt-Taylor, 2002; Leslie & McAllister, 2002). Other nursing research has been conducted from the etic, or outsider, perspective, whereby the phenomenon is described by the researcher who has not shared the experience (Spiers, 2000). The identity of the researcher as insider and/or outsider (Allen, 2004) has also been discussed in mental health research (see Camden Pratt, 2002). Stevenson (1996) has acknowledged that insider research is a reflexive form of research that has a valuable contribution to make to psychiatric nursing practice and research. Nursing research by insiders has been seen to provide advantages, such as encouraging trust in participants, providing knowledge of the structure and processes of the particular organization or culture being studied, and interpreting language or jargon used in the field (Leslie & McAllister, 2002; Pugh, Mitchell, & Brooks, 2000). Being an insider might also make the researcher theoretically sensitive, in that he or she might be accepted by participants as belonging to the particular "group," with less difficulty in establishing rapport (Bonner & Tolhurst, 2002).

Insider knowledge cannot, however, be assumed to provide complete access to a particular culture. That the researcher shares some attributes with the group he or she is researching has been troubled. It is unrealistic to assume that the researcher's knowledge is stable and unified and can illuminate all that can be known about a particular group (Olesen, 2000). Insider research can, therefore, bring with it potential problems, such as the assumption of knowing participants' views on issues and/or where participants might assume researcher knowledge or views on issues (Hewitt-Taylor, 2002). Overfamiliarization with the issue might then result in a lack of clarification sought by the researcher (Bonner & Tolhurst, 2002), and thus, questions might not be asked that could have provided further knowledge on the phenomenon.

Leslie and McAllister (2002) have argued, however, that it is the "nursedness" of nurse researchers, including their ability to give participants permission to share experiences on issues normally considered taboo, and the intimacy within such a relationship that encourage disclosure on the part of the participant. This provides an important tool that can enhance their access to participants' stories. McAllister (in Leslie & McAllister, 2002) has contended that in her experience as a psychiatric mental health nurse conducting an action research project, her role as an insider (i.e., nurse) gave her entrée to participants that had not been afforded other researchers. She also acknowledged she was an outsider in this situation, as she did not work within that particular hospital environment, and this role offered further benefits, as participants felt able to share with her their negative experiences with other hospital staff.

Coming to terms with being both insider and outsider

During my journey of wading through large amounts of literature and struggling to understand the myriad perspectives on insider research, my supervisor also challenged me to be suspicious of all binaries, suggesting that binary thinking was a tool of the mainstream, or dominant, paradigm, and that it often has the effect of forcing us to choose between one side or another. Instead, it might be possible to replace either/or thinking with both/and thinking. So, perhaps it is possible to be both self and other, it is possible to be both subject and object. I could be both adult child of a parent with psychosis—an insider—and qualitative researcher—an outsider—and both of these roles afforded me opportunities as well as challenges that might not be present if I were simply one or the other.

Sharing my autoethnography with peers

As part of the early stage of my doctoral journey, I have shared my experiences as an adult child of a parent with psychosis at psychiatric mental health nursing conferences. When I have declared this identity, reactions from people ranged from admiration, emotional recognition, and generous support, through to embarrassment and silence. In some cases, the recognition of their own experiences, as seen in mine, resulted in tears. I particularly remember a friend and colleague coming up to me at the end of my presentation with tears in her eyes and giving me a big hug. Sharing my experiences had evoked emotions from her childhood that, although it did not involve parental mental illness, shared some similarities with my emotional experiences.

I was certainly aware that it was unconventional and risky to speak about personal issues, when psychiatry, like medicine, has historically spoken from a detached and often critical observational stance. This was reflected in the comments of one of my other colleagues at the same presentation, who admired my "coming out" while also acknowledging that in some settings, this would have possibly resulted in the demise of my professional reputation.

I have not encountered any overtly negative reactions or criticism to date, but some colleagues have suggested that it was not wise to research an issue where I shared the same characteristics as the participants, that is, as an insider. Other colleagues have appeared slightly bemused that I would share my personal experiences with them (albeit within the conference setting), and some have maintained an awkward silence through which they have covertly expressed their discomfort. This would seem to be for a few reasons. Perhaps my sharing of childhood experiences, as occurred with my friend, evoked similar emotional experiences of their own. In this case, it might have raised uncomfortable or painful feelings they would rather not have felt. Perhaps, also, some colleagues who saw it as inappropriate, unprofes-

sional, self-serving, or simply unnecessary to disclose personal and private information in a public forum might have met the sharing of my experience with distaste or disapproval. Yet, if this was so, it seemed to me to be a curious, perplexing, and contradictory position for psychiatric mental health nurses to have. Mental health consumer and carer experiences have become increasingly accepted and valued within the conference setting and in written publications. Indeed, I have understood it was a central tenet of mental health services nationally and internationally that consumer and/or carer experiences are recognized and actively sought through consumer participation in services. Yet, perhaps there are also some lingering biases and stigma perpetuated even within the nursing profession toward people with mental illness and their families.

So why might my self-disclosure as a professional and as a family member apparently raise such diverse responses? Was it something to do with being an insider as well as an outsider in my research? Was it that, although "appropriate" self-disclosure (whatever each nurse understand this to be) in psychiatric mental health nursing is seen to have value, it might also involve inappropriate overstepping of boundaries by the nurse, whereby his or her needs rather than the consumer's are being met? Did my colleagues see my self-disclosure in the research context as analogous to inappropriate self-disclosure in the therapeutic sense, or was it to do with a perceived loss of personal control and the professional power and authority that might also be seen to be lost through such public self-disclosure? Did my apparent vulnerability—much as any consumer or carer might reveal when talking of his or her experiences—make me seem weak, powerless, or "too" subjective and thus affect my credibility as a researcher and/or nurse academic?

After having a "lightbulb" episode one day when I was reading some literature on the qualities of effective psychiatric mental health nurses and the characteristics of psychiatric mental health nursing, I wondered whether it might involve all of these issues to a greater or lesser extent. In addition, I was sharing my experience within the context of commencing my doctorate. The autobiographical use of self in research on the same topic has not been a conventional or perhaps even acceptable method for many nurse researchers who have studied within traditional notions of researcher objectivity, and some colleagues might not have approved of this. For these reasons, it seemed important to continue sharing about autoethnography as a tool that might enhance qualitative research.

Self-disclosure in psychiatric mental health nursing and qualitative inquiry

Self-disclosure, the sharing of personal information with others, has been recognized as an important issue within nurse-client therapeutic relationships in psychiatric mental health nursing (Ashmore & Banks, 2002; Gray Deering, 1999). It is also a concept that has been problematized, as although "appropriate" self-disclosure by the nurse has been recognized as facilitating reciprocal self-disclosure by the client and normalizing the client's experiences (Gray Deering, 1999), overstepping therapeutic boundaries with "inappropriate" self-disclosure has been seen as detrimental.

Disclosure of the nurse's personal experiences and/or feelings in psychiatric mental health nursing has generally been governed by the principle that although it might be helpful for the nurse to use self-disclosure as a way to enhance rapport within the therapeutic relationship, it is important not to reveal personal information that results in the focus of concern moving from the patient onto the nurse. Nurses who might have inappropriately self-disclosed through providing, for instance, personal contact details or engaging in a social and/or sexual relationship with clients pre- and/or postdischarge, are generally considered to have acted in an irresponsible or even unethical professional manner through violating therapeutic boundaries. This can result in harmful consequences for both client and nurse (Horsfall, Stuhlmiller, & Champ, 2000), and/or possible professional sanctions for the nurse.

The nature of researcher self-disclosure in qualitative inquiry can be seen as analogous to, and sharing some of the perceived benefits and disadvantages of, those identified by psychiatric mental health nurses. Notions of self-disclosure in qualitative research can range from, for example, choosing whether to reveal professional identity, through to disclosing shared experience such as pregnancy or motherhood to enhance reciprocity (Sword, 1999), and self-disclosing personal experiences and reflections through reflexivity and autoethnographic writing.

Researcher self-disclosure might reduce the hierarchical nature of the researcher-participant relationship (Sword, 1999), as well as encourage participant disclosure and facilitate trust and mutual identification within the relationship (McDonald, 2001). Self-disclosure might also make the researchers vulnerable and open them to criticism from others, including participants and other researchers (MacCormack, 2001; McDonald, 2001; Tierney, 1998). There is a risk that researcher self-disclosure could be viewed by participants as addressing the needs of the researcher rather than themselves (McDonald, 2001). Furthermore, as MacCormack and McDonald have attested, it might also raise painful feelings and a sense of lack of control in the researcher.

Yet, not self-disclosing might also leave the researcher open to criticism. Sword (1999), for instance, in choosing not to disclose her identity as a nurse to participants in her study, could be viewed as duplicitous and her lack of disclosure as affecting the trustworthiness of her research. As with many of the reflexive issues in qualitative research, it seems there are a number of tensions with regard to researcher self-disclosure. The decision of whether to self-disclose to participants, and, if so, what, when, or how much, remains a matter for the researcher to evaluate and justify using criteria for rigor and trustworthiness within their chosen methodology.

Coming to an understanding: My "self" in the research

I am now aware that my selfhood is a combination of complex, overlapping, competing, and shifting identities, formed as a child, a woman, a nurse, a mother, and a researcher. I am middle class and identify as an Australian. I am an adult child of a parent with psychosis and a psychiatric mental health nurse. These identities share a belief in the right to personal freedom and autonomy, acknowledge self-responsibility, and honor subjective experience, but these identities are not the same. A child's values differ from those of an adult woman. Having a parent with a mental illness sometimes places me in tension with my identity as a psychiatric mental health nurse. Identity is clearly not fixed. Thus, wounds and difficulties received in childhood can be transmuted into opportunities for insight and growth. As I have prepared for the field text collection and analysis phase of this research inquiry, I have come to see that experiences are diverse, and meaning is shaped by many things, including the experience, reflection on that experience, and conversing about it with those who might share points of similarity and those who do not.

Reflecting on the challenges and opportunities of using autoethnography in this narrative inquiry project

The opportunity to tell one's story and to reflect on what this might mean for engaging with research participants, who might have had similar or different experiences, helps to make one more self-conscious about the dynamics of researcher-participant relationship. Self-reflection enhances the ability to attend more consciously to participants' experience. There are some issues that the researcher needs to consider to promote rigor and quality when using autoethnography in qualitative research. Perhaps they might resonate as meaningful for others.

Transformative potential

Researching a personal topic issue offers transformative potential for self and others. In the first author's case, she has discovered personal attributes such as determination, courage, and strength and has come to see how individuals, regardless of the specific circumstances, can share their humanity with others at a deep and fundamental level. Knowing that others have trodden a similar path is potentially liberating and can relieve the burden of isolation and loneliness that many people suffer when keeping silent about the past. Experiences that have been seen as crises can become transformed into turning points or life lessons that enable the individual to move on to the future with both courage and renewed strength.

Sharing the common bond of personal experience might ultimately serve to transform the lives of the participants, other researchers, and the broader community.

Identifying as an adult child who had a parent with a psychosis

Researching intimate and emotional topics could raise personal issues for both the participants and for me as the researcher. One of the unexpected but beneficial aspects of the process of publicly sharing my personal experience through writing and presenting at conferences, however, has been the release of some emotional attachment to the issue. I have found that through the process of sharing my story, and reading about the research on children of parents with mental illness, I have become less emotionally bound to it in terms of my concept of my self and my history. I realize that I have become ready to attend to participants' experience, to see it in its fuller social context and thus to conduct rigorous research. Knowing that others share what I had previously thought of as a unique experience offers a sense of connection to them, and diminishes my sense and fear of being different. As Chesney (2000) also found, recounting one's life story opens an otherwise unavailable theoretical window in the research process.

Identifying as an ACOPP also offers potential challenges. When participants become emotional as they recall the past, while actively listening to these stories, I might have my own emotionality evoked, and there might be a temptation to retell my experiences at the expense of others. Having shared similar experiences with participants might also place the researcher in a privileged position. The multiple identities of ACOPP, mental health nurse, and educator offer some access to participants, because they might realize that I have a depth of knowledge, empathy, and understanding about ACOPP issues. This might enhance participant engagement, trust, and revelation throughout the research process.<D>

At the same time, there might be issues with which I cannot identify, for example when participants have a background that is markedly different from that of my own. With participants who are of different class, creed, gender, or nationality, or who have not experienced anger or grief as a result of their parent's illness, my experience might impede understanding of the participant's experience. Being an ACOPP who had a predominantly negative and emotionally difficult past might sensitize me to want to evoke and notice those same negative experiences in others and thus to be blind to positive experiences. Similarly, identifying as a psychiatric mental health nurse using a philosophy that tends to be problem-centered, aiming for restoration, palliation, or recovery, might lead to a tendency to be redemptive. What matters is that difference and commonality are consciously addressed, rather than dismissed or minimized throughout the meaning-making process.

Managing tension between objective detachment and subjective immersion: Using dialectical critique

It is possible to find a balance between objective detachment and subjective immersion, especially when questions and interpretations are freely shared within researcher-participant interaction. Dialectical critique is a specific strategy used in this study that has been helpful in finding balance between two seemingly opposite concepts and can deepen inquiry by consideration of counterpoints. A preliminary reflexive approach might be framed thus:

> How can I prepare for the field by being suitably dispassionate (with an eye on the big picture of what this event might mean), and at the same time genuinely empathic (so that I can approach with a level of subjective knowing)?

It is also true that when sensitive feelings and memories are evoked for participants, researchers should be willing and able to establish whatever conditions are needed to remedy the situation (Wilde, 1992). In this circumstance, subjective knowing is evoked to convey compassion, and also to facilitate meaning. Thus a following self-probe is

> How can I be sensitive to knowing when to disclose my own views and experiences and when to keep them aside?

Conversely, accessing subjective knowledge and being quick to self-reflect during data collection might also tend to inhibit participant disclosure and provoke prompt agreement rather than seek explanation of his or her personal reality (Morse & Field, 1995). It is helpful, then, to remember that research and therapy are not the same and that, on balance, the participant is the one who has the primary role in revealing honest and meaningful information.

Approach to field text collection in this research

Unstructured interactive (narrative) interviews

In this inquiry, it was initially envisaged that a reflexive dyadic interview would be used (Ellis & Berger, 2002). It became apparent early in the field text collection phase, however, that because of the nature of the participants' often painful experiences, this interviewing approach was not particularly suited to their needs. Instead, unstructured interactive interviewing, also known as narrative interviewing, has been used. With this type of interview, the participants have significant control, as they decide where to begin their story, what they will speak about, in what order, and in how much detail. The researchers' role in the unstructured interactive interview is active in the sense that they provide attentive listening and may ask questions, probe, and respond to questions, but the focus throughout remains on the participant and his or her story (Corbin & Morse, 2003). In this study, because of logistical constraints preventing multiple interviews with each participant, one lengthy unstructured interactive interview of between 60 and 90 minutes was conducted with each participant, along with a follow-up phone call. E-mail communication also occurred with some participants. Each participant was invited to member-check his or her interview transcript and was able to clarify, change, add, or remove any information about his or her experience before the transcripts were analyzed.

The first author, in the eventual telling of the story of the research, will be reflecting on the personal experience that brought her to the topic. She will discuss what she learned about it and her emotional responses during reading about it, writing on it, and interviewing and responding to and with the participants. This includes how she used her knowledge of self and/or the experience of being an ACOPP to understand what the participants were saying (Ellis & Berger, 2002). Our aim with this added layer of autoethnography is to produce findings that seek to add a contemporary and authentic dimension to the existing knowledge on the experiences of ACOPP and to the methodological use of self in research.

Noticing and using emotion

Many research methods, such as structured interviews, surveys, and some field notes, focus on knowledge or experience outcomes. Emphasis is placed on what was said, what happened, or how many people thought this or that. Few methods focus on processes such as how things are said; what is happening to change peoples' minds, sway beliefs, or trigger memories; what emotions are being stirred; and how the researcher and participant are feeling throughout the exchange. Noticing emotion might help to alter conversation to probe more gently, to explore more deeply, and to link experiences, thoughts, and feelings. This process helps researchers attend to the subjective.

In a reflexive approach to interviews, comments that notice or evoke participant emotion could include

- I guess that experience must have been pretty confronting. How did you feel throughout it?
- I notice that you've gone a little quiet. Is this issue difficult? How would you like to proceed?

Afterward, when the researcher is interpreting data, critical self-reflections could include

- Gee, I was feeling really embarrassed at that point. I wonder why. Maybe I should talk with Ms H further about my feelings then.
- I just cannot understand why that had to happen to G. The system really gets me mad! Hang on a minute…this is an example of subjective immersion. How can I also look at this dispassionately?

This last self-reflective comment is a further example of dialectical critique and is useful in thinking critically about a concept and in gaining balance between tensions such as objectivity and subjectivity. Once an interpretation has been constructed, the researcher can also construct its opposite and consider the validity of that belief. In this way, a rigorous and accountable approach to research analysis is enhanced.

In this article, we have expanded on the challenges and opportunities of autoethnography in a narrative inquiry and answered several questions that might be useful for qualitative researchers. We argue that autoethnography is relevant for qualitative researchers because it acknowledges a self-conscious orientation that allows examination of his or her background, history, and experience, and this is particularly relevant for psychiatric mental health nurses, as it is synchronous to the need for self-awareness. The researcher's position is not static but dynamic. Self-reflection, examination of the literature, and the experience of undertaking the study combine to provide new perspectives for participant, researcher, and reader. A reflexive stance allows for the development of a dialogical relationship with the participant, and autoethnography is used as a way of surfacing the researcher's experience to shed light on the culture that is being studied. When using autoethnography as a research method, the technique of dialectical critique might assist in managing the tension between objective detachment and subjective immersion.

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