18

The Lived Experience of a Qualitative Health Psychologist

Rachel L. Shaw

Starting Out

I became a Chartered Health Psychologist[1] in 2004; arriving at this place in my professional career involved several twists and turns and it isn't the route I expected to take when I embarked on this journey fresh from A levels aged 18. I chose French, English language and geography at A level and intended to read French and linguistics at university. However, I didn't quite make the grade for my first-choice university and ended up opting for De Montfort University's BSc Psychology of Human Communication with French instead. This turned out to be the best thing I ever did! Psychology of human communication covered both linguistics and psychology and so satisfied my desire to study linguistics but it also introduced me to psychology. At the same time I was keeping up my French. Perfect.

From the outset, I was fascinated by psychology. I was intrigued by the 'staple' subdisciplines of developmental and social psychology although I was less enthused by cognitive psychology and statistics. I also enjoyed sociolinguistics and psycholinguistics. What really grabbed me were the modules which were to the traditionalist a little 'off the wall' and possibly perceived to be out of place in a psychology programme; I remember in particular *Mind, Meaning and Discourse* and *Film Studies*, both convened by Dr Dave Hiles. We thought it was fantastic that we could watch a film on a Wednesday afternoon and call it work; it was this inauspicious beginning that inspired my doctoral research and I'll never forget the significance of narrative illustrated in the classic 1987 Rob Reiner film, *Stand by Me*.

Mind, Meaning and Discourse began with Dave standing at the front of the lecture theatre with a wooden spoon and asking us what it was. Eventually, once we'd

Health Psychology in Action, First Edition. Edited by Mark Forshaw and David Sheffield.

overcome our inherent student apathy toward the dreaded interactive lecture, people began to shout out things like 'booby prize', 'wedding present', 'wedding anniversary' (the fifth wedding anniversary is represented by wood), 'puppet' (once dressed – like they used to feature on *Blue Peter* when I was growing up) as well as the obvious, 'cooking utensil'. Dave was illustrating that multiple meanings of the same object co-exist and that different people might attribute different meanings to the same object, event or feeling. In short, he was demonstrating the postmodern assumption that reality is not static or unitary but fluid, dynamic and intersubjectively constructed in a way that is bound by time and place. This spoke to me because throughout the earlier modules I had questioned the generality of theories presented and wondered how we might consider the cultural, historical and personal context within our study of human experience and behaviour. This different approach seemed to offer a possible way of answering these questions.

Another key moment for me, which consolidated my interest in the conceptual foundations of psychology and the sociology of scientific knowledge, was the final-year module, *Conceptual Issues in Psychology*. This module introduced me to Kuhn's (1962) notions of paradigms and scientific revolutions and I began to realize that science (particularly but not exclusively when directed at the human subject) is not an objective fact-finding exercise but a complex journey of discovery that takes place within the sociopolitical and historical climate; science is not neutral or value-free but the product of human interaction and interpretation. This brief flirtation with philosophy sparked a deeper interest in the epistemology of psychology which led me, via Reason and Rowan's excellent (1981) *Human Inquiry*, to Wilhelm Dilthey's distinction between the natural sciences and the human sciences: 'nature we can explain, man [*sic*] we must understand' and to Donald Polkinghorne's (1988) *Narrative knowing and the human sciences*.

Since then, I have had a passion for a psychology that takes a human science approach and prioritizes meanings, subjectivity and context. Giorgi (1970) called this a phenomenologically sensitive psychology, Jonathan Smith has referred to it as experiential psychology, and many others understand it as qualitative psychology.[2] My commitment to qualitative methods in psychology is the one constant in my career. Since my undergraduate final year research project I have used qualitative methods and through the years have become known as a qualitative psychologist.

You may be forgiven for wondering what this has to do with health psychology, but it was my expertise in qualitative methods that introduced me to subject. My first postdoctoral research post was in the Health Services Research Centre[3] at Coventry University. I was employed on the Breastfeeding Best Start randomized controlled trial. My role was split into three main tasks: overseeing the data collection and qualitative analysis of interviews conducted with mothers taking part in the trial; managing midwives' involvement in recruitment at antenatal clinics and delivering the intervention on the postnatal ward; and carrying out a series of focus groups with midwives following their participation in the trial to explore their experience of it. Applying qualitative research techniques to this real-world scenario was an excellent footing on which to develop my research profile.

Finding My Niche

One thing you notice as a student and early career researcher is that academics tend to specialize and this can be in one particular substantive topic (e.g. diabetes), or perhaps in one area of work (e.g. behavioural interventions in primary care). The challenge I faced was deciding which specialism would suit me. For a while I didn't really feel at home in health psychology; when I was in training, health psychology hadn't entered my world. Nevertheless, for several years following my PhD I did primary and secondary research in health psychology. As a doctoral student I had immersed myself in philosophy and tussled with the complicated constructs of phenomenology including intentionality (which has nothing to do with intending to do something), the life-world and Heidegger's (1962) Dasein (there-being or being-in-the-world). As a postdoctoral research associate these were things that rested in the back of my mind while I began to answer the more mundane yet critical questions, such as how to persuade midwives to recruit young pregnant women to an interview study about their infant feeding choices in a 10-minute slot which is already full to the brim with essential information (and that's without even touching on the midwives' own beliefs about breast and bottle feeding).

I soon began to learn about the National Health Service; its oblique systems, lack of resources and the sterling efforts required by its staff. Working in this context was a reality check that woke me up to thinking about research questions that matter to real people. My next challenge was to find a way of marrying that applied focus with my expertise in qualitative methodology. This wasn't immediately obvious and it took a while for me to gain the confidence to position myself (as I do now) as a qualitative health psychologist who can offer something worthwhile to a research team.

The value of qualitative methods – known for their ability to make sense of the messiness of human experience – in the complex and pressurized context of the health service was almost self-evident: qualitative research is iterative, designed to deal with the real world; it produces in-depth, subjective accounts from which we can ascertain the cares and concerns of individuals (whether patients, practitioners or carers); it enables us to explore how people feel and how their health beliefs are negotiated and constructed dependent on their personal relationships, everyday interactions with people around them and with society at large. In short, qualitative research can look beyond the surface and explore people's beliefs and the decisions they make by asking them to reflect and tell stories about things that have happened to them. By treating people as experts of their own experience, we show them respect, prioritize them and are able to see the world as if we were in their shoes. It is not always easy to see things from someone else's perspective and so it is not surprising that health care professionals and patients often interpret things differently and have different expectations about the outcome of a consultation. Similarly, we know that individuals do not act in isolation; decisions we make, especially those that might impact on our own or our family's health, are often influenced by a whole raft of things including the economic, social and political climate, our religious beliefs, the cultural practices we engage in, the family traditions we have always partaken in, our

educational level and our role(s) in society (for instance as a professional, parent, political representative or voluntary worker).

Once we accept as fundamental our inherent interconnectedness with the world in which we live, we begin to realize that to understand health and illness experience we need to understand the person-in-context; I believe the only way we can do that effectively is to employ qualitative research methods either on their own or in conjunction with other approaches (including large scale-surveys, experiments and randomized controlled trials). Hence, I found my niche. I am a qualitative health psychologist who works to make sense of individuals' experiences of illness: I explore the factors that come together to make up people's health beliefs and how they impact on their health management; I pay attention to the context in which health is managed and so take as a priority the need to understand the experiences and beliefs of carers, other family members and health care professionals as well as patients; and finally, because constructs of health and illness are contingent on the stories that circulate in the media, I investigate the content and functionality of the media and people's interactions with it, especially the internet, news media and 'celebrity culture'.

The Work of a Qualitative Health Psychologist

As summarized above, my objective in the work I do is threefold: to understand people's experiences of health and illness and what those experiences mean to them within the context of their everyday lives; to make sense of the interrelationships between patients, health care professionals and carers or family members to help the individuals involved see things from a different perspective and therefore understand each other better; and to describe current practices as experienced by different stakeholders to establish examples of best practice which will help all involved. This is a particularly ambitious (and probably never ending) project which I have chipped away at during the years but it is one that I am committed to and genuinely believe is worthwhile. Alongside this substantive project is a secondary objective: to raise the profile of qualitative research methods in health psychology and within the hierarchy of knowledge. To achieve this aim, I am committed to qualitative methods training and showcasing the benefits and successes of qualitative methodology within a discipline whose focus is to make sense of human experience and behaviour. Consequently, I am engaged in a number of different activities as a qualitative health psychologist.

One example is a qualitative interview study with patients and health care professionals involved in the DESMOND randomized controlled trial, which I conducted with colleagues at the University of Leicester (Ockleford, Shaw, Willars & Dixon-Woods, 2008). Our remit was to explore patients' experiences of the group education intervention in self-management for patients newly diagnosed with Type 2 diabetes and to gather health care professionals' accounts of delivering this intervention or standard care and their experiences of working with diabetes patients. We found differences of opinion about the group format of the intervention, demonstrating

that health care professionals and patients don't always see eye to eye about the most effective method of consultation; some patients preferred doing their own research and negotiating appropriate treatment and lifestyle changes, while others preferred the traditional didactic approach; this wasn't necessarily associated with demographic factors such as age. We also found that an individuals' acceptance of their identity as someone with diabetes impacted on their readiness to accept the severity of the disease and the longevity of lifestyle changes made in accordance with professional advice. The trial's 3-year follow-up results also observed a significant difference between the intervention and control groups' illness beliefs: scores for patients' beliefs in coherence, timeline, personal responsibility and seriousness were significantly higher in the intervention group. This example demonstrates how qualitative and quantitative research can work together in a complementary way. The questionnaire data from the DESMOND trial had identified personal responsibility and seriousness as constructs affected by the intervention; through our qualitative work we were able to provide further detail and suggest that it was patients' readiness to accept a change in the way they viewed themselves (i.e. as a person with diabetes), together with their beliefs about the seriousness of the condition that impacted most strongly on their ability to manage their condition. What we gain from the qualitative work is a sense of how illness beliefs might be functioning in relation to a person's identity and outlook, which emphasizes the need for appropriate interpersonal relationships between health care professionals and patients so that practitioners can get to know their patients and therefore make informed choices about the best way to manage their care. Of course, what qualitative research often shows is that there are no shortcuts in developing effective and satisfactory health services. Group education can have wonderful effects on people (and some participants in our study particularly valued sharing their experiences with others) and there are obvious benefits in terms of resources (finance, time, staff) but it doesn't suit everyone. Nevertheless, because qualitative research prioritizes the person it reminds us of the need to respect individuals and the importance of maintaining personalized care within the NHS.

A second area of my work involves the media. I am interested in how health issues are framed in the media in order to favour one particular message over alternatives and have worked with my colleague, David Giles at the University of Winchester, to develop Media Framing Analysis as a method for analyzing media content that focuses on qualitative analysis of narrative, character construction and portrayal, language use, and the generalization (or repetition) of historical and cultural phenomena (Shaw & Giles, 2009). One study examined media representations of celebrity drug use, using Amy Winehouse as a case study, with a view to exploring what young people make of celebrities like Winehouse and how stories of illegal and destructive behaviour might impact on their own beliefs systems and sense making in relation to drug use (Shaw, Whitehead, & Giles, 2010). The Media Framing Analysis revealed a sudden shift in messages portrayed in the news media and an especially rapid fall from grace for Winehouse; initially Winehouse's behaviour was framed with a nostalgic tone as that of a typical 'rock star', but within a year news

reports seemed to become impatient with Winehouse's recklessness and cast her as a hopeless case who should sort out her problems. Indeed, the young people who took part in focus groups in this study had also tired of Winehouse's alleged drug use and apparent inability to take control of her behaviour. Nevertheless, the issue did spark a debate about the media's role in society and its potential impact in terms of glamorizing drug use. One focus group revealed mixed views among the young people who participated, Sam[4] remarked:

> It's just glamorizing it, it's not making it look bad.

To which SJ replied:

> They do make it look rank [unpleasant] though. I don't want to look like Pete Doherty and Pete Doherty has no money, Amy Winehouse's husband is in prison, how is that glamorizing it?

This study illustrated young people's ability to critically appraise what they read in the media amidst fears of 'copycat' behaviour influenced by early work in behavioural modelling. The key benefit of carrying out in-depth qualitative analyses of both media content and group discussion data about that content is its sensitivity to the nuances within human understanding. The media data demonstrate the apparent unceasing cycle of idolization quickly followed by scandal and vilification and they are important in health psychology because they represent the pervasiveness of celebrity culture within contemporary society and its potential to impact on individuals' health beliefs.

A clear cut example of the power of the media in relation to health beliefs and decision-making behaviour is the infamous measles–mumps–rubella (MMR) and autism debate. I carried out a Media Framing Analysis of news stories following the press release in 1998 about Andrew Wakefield's research which tentatively suggested a link between the MMR vaccination and autism (Shaw, 2005). This quickly led to a radical drop in uptake of the vaccination as well as a subsequent increase some years later in (sometimes fatal) cases of measles. Consequently, I believe it is imperative that health psychologists approach health concerns within their social and cultural context and that part of this task is to understand the function of the media in generating discourses of health and in contributing to the frame of reference individuals use when making decisions about their own and their family's health.

Thirdly, the exponential growth of the internet and websites devoted to health has led to the birth of a new field in health psychology, ehealth. The internet has the potential to radically change the way we function in relation to our health; it is possible to seek advice and support from health professionals and others with the same condition, to self-diagnose, and to buy self-testing kits and treatments online. The key challenges provoked by these virtual consultations and peer- or self-diagnoses are concerned with the validity of information and the accreditation of products available. A focus group study with health care professionals and members

of the public carried out by Louise Donnelly as part of her doctoral programme (which I supervised) demonstrated that increased internet access can lead to a decline in expert authority; participants felt capable of making sense of health information online and in some cases used this to challenge their GP in a way they wouldn't have done without the internet (Donnelly, Shaw & van den Akker, 2008). Furthermore, some individuals felt empowered by the availability of information online and found it served them better, mainly due to its convenience, than using traditional health services. This notion of the virtual patient and its implications for health management I think are crucial in future health psychology research and are certainly high up on my own research agenda.

Finally, I will illustrate the potential impact qualitative health psychology can have on the real world. The examples above illustrate the close links between the research I do and the lived experience of individuals in contemporary society; the focus on everyday experience and people in context is a major strength of qualitative methodology. Furthermore, qualitative research in health psychology can reveal flaws or omissions in current practice and help inform the design and implementation of new systems. Working from an evidence base in developing health care systems is paramount and historically, the 'gold standard' of evidence used in this way comes from systematic reviews of randomized controlled trials testing drug or behavioural interventions. Nevertheless, other types of evidence including that generated by qualitative research has been recognized for some time and is beginning to filter into the consciousness of funding bodies, policy makers and practitioners. Indeed, carrying out metasyntheses of qualitative evidence seems to be in vogue. Several of my PhD students are doing a metasynthesis alongside a more traditional systematic review of quantitative evidence and a number of training courses are now available in methods for conducting metasynthesis. Furthermore, I have written a chapter on this very subject for a textbook on qualitative methods for psychologists and psychotherapists (Shaw, 2011). This increased recognition of qualitative research demonstrates its new found significance within the hierarchy of evidence and together with continually growing proportions of qualitative research published in health services research, medical and health psychology journals consolidates the place of qualitative methodology within the scientific community.

A more direct way in which qualitative research can impact on the real world is to obtain funding from the NHS, charities or private companies involved in health care research and/or drug development that invest in applied scientific research within the health care setting. For example, I currently have two PhD students working on programmes of research of this nature. Christian Borg Xuereb is part-funded by Bayer Healthcare[5] to carry out a phenomenological study of patients' and physicians' experiences of living with or prescribing warfarin. Christian's research is a sister project to a randomized controlled trial of a psychological, educational intervention for atrial fibrillation patients on warfarin run by fellow PhD student, Danielle Smith. Both are working with clinical supervisor Dr Deirdre Lane and are based at a local hospital; I am Christian's academic supervisor and Danielle's is Prof Helen Pattison. Christian's work is closely linked to National Institute for Health and

Clinical Excellence (NICE 2006) guidelines for managing atrial fibrillation and his in-depth qualitative research has two objectives: to explore patients' experiences and beliefs in order to make sense of their decisions to accept or decline warfarin and to determine the rationale behind physicians' decisions whether or not to prescribe warfarin in particular circumstances. Managing potential risk is paramount in this area: the key concerns are overcoming patients' worries about the risk of stroke and bleeding and enabling physicians to feel confident in explaining those risks in a way that patients can understand in order to make a decision about appropriate treatment. Getting into the 'nitty gritty' of both patients' and physicians' perspectives on warfarin and risks will therefore help devise effective strategies for risk assessment and decision making that will benefit both patients and physicians.

Adrienne McCabe is funded by a West Midlands Nursing, Midwifery and Allied Health Professions Research Training Award, and her research is set in a Paediatric Intensive Care Unit. Adrienne's work follows on from her previous work which developed a Paediatric Early Warning System (McCabe & Duncan, 2008). Her doctoral research takes a phenomenological approach to explore nurses' and doctors' experiences of unexpected life-threatening events on the paediatric ward; within this Adrienne is investigating the methods of feedback and debrief that are in place as well as any related time off work, stress or distress experienced with a view to developing strategies to prepare nursing staff for such events and designing appropriate systems for providing feedback, debrief and support. Alongside this, Adrienne is involved in other tasks including an international survey of current practice for preparing staff for an unexpected life-threatening event as well as a systematic review of the literature. This programme of research will feed into further postdoctoral work which will develop and test an intervention to prepare and support staff in these circumstances. If successful, this intervention has the potential to be rolled out nationally and therefore have considerable impact on nurses' everyday experience, training and job satisfaction as well as on the care of patients and their families.

Other equally important areas of my work include training and consultancy. As introduced above, the objective underlining these activities is to promote the benefits and successes of employing qualitative methodology in health psychology research. This is a valuable enterprise due to the growth of qualitative health psychology and the related increased demand for both training in qualitative methods and applied research taking a qualitative approach. A good example of consultancy in the shape of research is a tender we won to carry out a qualitative evaluative study of the cardiovascular screening programme within the Heart of Birmingham teaching Primary Care Trust (HoBtPCT). Alongside quantitative analyses of biomedical and questionnaire data, HoBtPCT required an in-depth qualitative study of patients' and health care professionals' experiences of being involved in the screening programme. In addition, they required a systematic literature review of qualitative and quantitative evidence about the success or otherwise of cardiovascular screening programmes elsewhere. A great benefit of qualitative health psychology is its ease of application to the real-world setting which, together with our expertise in systematic reviewing, is attractive to organizations that commission research. As a team within the Health &

Lifespan Psychology Research Group at Aston, we are able to market our skills set and attract such consultancy work which both further develops our track record and raises our profile in the sector.

I also carry out consultancy work in the form of designing and delivering short training courses in qualitative research methods. I have done this in a variety of ways. I have delivered bespoke training courses in qualitative methods under the auspices of Community Pathways CIC (a consultation and research company that employs local people to carry out research and consultancy within the region) as well as for organizations such as the Health Research & Development Unit (part of the East of England NHS Research and Development Support Unit). Mostly, I offer one day training courses in Interpretative Phenomenological Analysis (IPA) here at Aston University. These courses provide Continual Professional Development (CPD) for practitioners in health, education and social work, doctoral or contract researchers, academics and others interested in developing their research skills. IPA has become a particularly attractive method in health psychology and the courses I run have attracted delegates from across the United Kingdom as well as from Ireland, Australia and Canada. Delivering these courses is a really enjoyable part of my job; I meet people from diverse fields doing fascinating research in a range of disciplines. I value this work because it keeps me in touch with the world outside health psychology; I find mixing in interdisciplinary circles is a great stimulation for developing research ideas of my own.

On top of this CPD training, I have also been involved in work to develop online resources for teaching qualitative methods in psychology, a project funded by the Higher Education Academy. Resources such as these will benefit both students and lecturers which will help build capacity in the shape of future qualitative researchers. I feel that work of this nature is worthwhile and part of my duty as an expert in the field. I am after all an educator and so am committed to the advancement of knowledge and skills especially when they contribute to the profile of qualitative health psychology.

Summing Up

The life of a qualitative health psychologist is a busy one! It is also varied, creative and inspiring. I have taken as read (perhaps in error) my involvement in undergraduate and postgraduate teaching and attendance at national and international conferences as these are the activities which feature most prominently (especially the former) in the life of a lecturer. Instead I have focused on those activities which characterize my passions and commitment to qualitative health psychology. Being a qualitative research in psychology often comes with a feeling of marginalization from the mainstream in the typical 'outgroup' sense. However, I no longer feel the need for continual justification for using words instead of numbers in the work I do. Great leaps have been made in recent years with thanks to people like Prof Jonathan Smith, Prof Michael Murray, Prof Kerry Chamberlain and Prof Lucy Yardley among others,

all well known for their commitment to qualitative methods in health psychology. It is a vibrant field of which I am happy to be a part. In fact, I would go as far to say that as a qualitative researcher I feel at home in health psychology.

Key Debates in Health Psychology

I've just had an MSc Health Psychology student come and talk to me about a project idea: he is interested in asthma among young people from low socio-economic backgrounds. The dilemma he posed to me was whether to opt for a project about illness representations using Leventhal's Commonsense Model of Self-Regulation of Health & Illness as a framework or an experiential project which takes Heideggerian phenomenology as its theoretical background. My response (somewhat to my own surprise): the two aren't mutually exclusively; in fact one could argue that their objectives would be the same even though the methods used might differ substantially. After I'd told the student to go off and do some reading and to come back when he's got a clearer idea of his specific research question (which will – in theory – help determine which approach and methods will be the best fit), I found myself reminiscing about the realization I had many years ago that interpretative phenomenological analysis (IPA) is all about cognition! As a student I took an instant dislike to cognitive psychology and anything associated with it. Now, as a more mature qualitative health psychologist I know that studying cognition isn't limited to the infamous computer analogy or information-processing flowcharts; on reading Jerome Bruner's work, I realized that cognition put another way is meaning making. This notion of meaning making appealed to me because of its focus on meaning but also because it attributed agency to the individual who makes meaning (i.e. makes sense of something).

I believe that a key concern of health psychology is to understand the ways in which people make sense of things. This is a view that was clearly shared by many others as health psychology began to grow and develop, evidenced by the dominance of illness representations and social cognition models, including the seemingly omnipotent theory of planned behaviour, in health psychology research. My 'Eureka' moment brought home to me the closeness, in objectives at least, between historically distinct approaches. It also left me feeling bewildered about the (im)possibility of ever bridging the epistemological divide between the 'traditional' health psychology models and the 'new paradigm' approaches which used qualitative methods.

Recently, I have become more optimistic about this venture. Lucy Yardley's work promoting Dewey's pragmatism in an attempt to draw attention to the multifaceted nature of knowledge (and by extension the multiple methods which might produce scientific knowledge) has also advanced this debate

from previous iterations about mixing methods. Like Lucy, I think we need to go beyond the idea of mixing methods, which can lead for example to 'watered-down' qualitative studies tagged onto the end of a large-scale survey which are neither use nor ornament. Instead, we need to think of ways of being creative and designing truly integrative projects. To do this we need to peel away the barriers between positivism and interpretivism and engage with their assumptions at a basic level to identify the essence of their objectives. This I envisage as an epistemological dance rather than the wrestling matches of yesteryear; taking to the floor with an air of openness and a shared desire to achieve a sense of knowing may help us feel the music in our bodies and start us moving to the same rhythm.

Notes

1 At the time this was a title awarded by the British Psychological Society (BPS) which was superseded in 2009 by the Health Professions Council's (HPC) protected titles of Practitioner Psychologist and Health Psychologist. The title Chartered Psychologist is still valid for those Chartered by the BPS without an applied specialism or in addition to the HPC specialist title.
2 Qualitative psychology usually incorporates a far broader range of methods, however, including those focusing on discourse such as conversation analysis and discourse analysis. Experiential psychology does not study language in its own right; instead, its objective is to use language as a path to making sense of lived experience.
3 Now called the Applied Research Centre in Health and Lifestyle Interventions.
4 Pseudonyms are used to protect participants' anonymity.
5 Christian's PhD is funded jointly by an Investigator-Initiated Educational Grant from Bayer Healthcare and University of Birmingham's Centre for Cardiovascular Sciences, Sandwell and West Birmingham Hospitals NHS Trust.

References

Burden, A.C. (2010). Rapid response: to show the benefit of targeting cardio vascular disease screening. *British Medical Journal*, *340*. doi:10.1136/bmj.c1693. Retrieved from http://www.bmj.com/content/340/bmj.c1693/reply

Donnelly, L.S., Shaw, R.L., & van den Akker, O.B.A. (2008). eHealth as a challenge to 'expert' power: a focus group study of Internet use for health information and management. *Journal of the Royal Society of Medicine*, *101*, 501–506.

Giorgi, A. (1970). *Psychology as a human science: a phenomenologically based approach*. New York: Harper and Row Publishers, Inc.

Heidegger, M. (1962/2004). *Being and time*. Trans. J. Macquarrie & E. Robinson. Oxford: Blackwell.

Khunti, K., Heller, S., Skinner, T.C., Gray, L. J., Dallaso, H., Realf, K., Carey, M., & Davies, M. (2010). Randomised controlled trial of the DESMOND structured education programme for people newly diagnosed with type 2 diabetes: follow-up results at three years. *Annual Professional Conference of Diabetes UK,* 3–5 March, Liverpool, UK.

Kuhn, S. (1962). *The structure of scientific revolutions.* Chicago: University of Chicago Press.

McCabe, A., & Duncan, H. (2008). National survey of observation and monitoring practices of children in hospital. *Paediatric Nursing, 20*(6), 24–27.

National Institute for Health and Clinical Excellence (NICE). (2006). *Atrial fibrillation: the management of atrial fibrillation.* NICE Clinical Guideline 36. Developed by the National Collaborating Centre for Chronic Conditions. London: National Institute for Health and Clinical Excellence.

Ockleford, E., Shaw, R.L., Willars, J., & Dixon-Woods, M. (2008). Education and self-management for people newly diagnosed with type 2 diabetes: a qualitative study of patients' views. *Chronic Illness, 4*, 28–37.

Palmer, R.E. (1969). *Hermeneutics.* Evanston, IL: Northwestern University Press.

Polkinghorne, D.E. (1988). *Narrative knowing and the human sciences.* New York: State University of New York Press.

Reason, P., & Rowan, J. (1981). *Human inquiry: a sourcebook of new paradigm research.* Chichester: John Wiley and Sons Ltd.

Shaw, R.L. (2005). Can we communicate health risk without causing hysteria? Making sense of the MMR scare. Oral presentation at the Critical Health Psychology Conference, 29 March–1 April, Sheffield, UK.

Shaw, R.L. (2011). Identifying and synthesising qualitative literature. In D. Harper & A. Thompson (Eds.), *Qualitative research methods in mental health and psychotherapy: an introduction for students and practitioners.* Oxford: Wiley Blackwell.

Shaw, R.L., & Giles, D.C. (2009). Motherhood on ice? A media framing analysis of older mothers in the UK news. *Psychology & Health, 24*(2), 221–236.

Shaw, R.L., Whitehead, C., & Giles, D.C. (2010). 'Crack down on the celebrity junkies': does media coverage of celebrity drug use pose a risk to young people? *Health, Risk & Society, 12*(6), 575–589.

Wakefield, A.J., Murch, S.H., Anthony, A., Linell, J., Casson, D.M., Berelowitz, M., Dhillon, A.P., Thomson, M.A., Harvey, P., Valentine, A., Davies, S.E., & Walker-Smith, J.A. (1998). Ileal-lympoid-nodular hyperplasia, non-specific colitis, & pervasive developmental disorder in children. *The Lancet, 351*, 637–641.