The Insider Researcher

Howard Mitchell

As a novice, starting project work for the first time, my concept of academic research included the assumption that a necessarily detached standpoint was required in the search for objective truths. Like many, I had some hazy image of research which was based on the natural sciences; the laboratory, the white coat, the breakthrough. With the social sciences, fieldwork replaced the laboratory, but for many years the methodologies of the more established and higher-status sciences provided the template for research. With this template came the associated premise: knowledge is a neutral portrayal of fact achieved through impartial collection and analysis of data. [...] 

My initial grasp of research and the little I had discovered of methodological theory provided me with problems concerning the area that I wanted to do my own research in.

I was no ‘outsider’ and I did not want to describe any ‘otherness’. I was an insider to the subject area and many of the people and practices I wished to investigate. Could I be ‘scientific’ and objective with a subject I was so familiar with and just where and how would I address this or even acknowledge this in my work? I had no theoretical framework to apply.

My insider status

I was born in Lennox Castle Hospital in 1955. For 23 years, several of the wards which were purpose built for patients with a mental deficiency were converted for use as a maternity unit. I grew up in the village of Lennoxtown, living 400 metres from the hospital entrance. My family were in the minority in our street in that none of us worked in ‘The Castle’ at that time. I could not help but be aware of the institution throughout my childhood. Sunday walks were often along the hospital drive and around part of the grounds and the staff housing. We would usually be engaged in conversation by some of the patients and the redbrick villa where I was born was pointed out.

In our block of terraced council housing the three other families consisted of:
husband and wife, both nurses at Lennox Castle; 
mother, son and daughter, all Castle nurses and the father, latterly 
boiler room worker; 
father (Castle van driver) and daughter (domestic worker).

This was typical of Lennox Road. If there was a house where no 
member of the family had some attachment to the hospital then it was 
unusual. Irate nightshift workers regularly interrupted my football 
training regimes as I curled free kicks against their bedroom walls. 
The children from the staff houses went to a one-room school in 
neighbour Campsie Glen along with those from outlying farms and com-

cmunities and joined the rest of us in Lennoxtown primary in primary 
five. I became close friends with one of the ‘Castle kids’ and spent a 
few years of my adolescence around the Oval. I became party to some 
of the lore surrounding the hospital and thoroughly explored the large 
grounds. There were no frightening or threatening connotations 
attached to the place at all for me. I would regularly cycle home from 
my friend’s house in the dark, through the grounds, when I was 12 and 
13, with little trepidation. Major preoccupations at the time were, who 
was allowed to play in the Oval – the children jealously guarded their 
swings from anybody from Lennoxtown – and who owned the hospital.

My recollection of any kind of view I had about the patients who 
inhabited Lennox Castle is hazy. Certainly news of escaped patients 
seemed to filter down to us as children but there was no attempt in my 
family to use the hospital or the patients as a means of control – no 
bogeyman stories. I grew up with a benign acceptance. From any 
dealings I had with the patients I took them to be talkative and 
amusing. There were several individuals in the village who were 
recognized as ‘simple’. They stayed with their families and were sub-
jected to varying degrees of intolerance. I did not equate them with 
patients from the Castle.

For my first 19 years I lived adjacent to the institution, had been 
aware of the part it played in employment for much of Lennoxtown, 
had seen the separate community that was the staff housing, had had 
limited contact with some of the patients, but I had little idea what 
happened inside the wards. I benignly accepted the existence of the 
hospital and can recall little curiosity.

Unemployed, a friend and I were ushered into starting as nursing 
assistants in Lennox Castle by a friend of our families who was senior 
tutor there. We commenced on the same ward on the same day and 
were orientated by a nurse who was my next-door neighbour. Adjust-
ing to working with the range of patients we encountered was 
challenging. There were some with gross physical deformities, some 
tiny people, some huge. From these bodies some would scream or 
grunt all day and some would hold interesting conversations with us. 
Some patients would tear all their clothes off, break windows and try
to run away. Some would try to sell us TVs or tape recorders they had acquired while out on pass in Glasgow. Some appeared sensible and wise. It took me many months before I had any clear idea of what mental deficiency, as it was called then, was.

Adjusting to the range of staff who we worked with was also challenging. Some seemed cruel and indifferent to the patients but most were caring and giving. All were welcoming to us initiates in their own ways. The personnel all seemed slightly eccentric in one form or other but were full of personality.

It was a culture totally different from anything that I had encountered before. I had worked in various jobs and had grown up in close proximity to the hospital and knew many of the people associated with it but the inside environment was still totally unexpected. It was shocking in many ways but also exciting and embracing. The sheer novelty of such a range of characters – both patients and staff – and the lively social life surrounding the workplace was intoxicating.

I took nurse training there and was a charge nurse for a year before leaving to do general nurse training and eventually attend university. Over the five year period that I worked in Lennox Castle my feelings and opinions inevitably shifted. The stimulation of many new and odd acquaintances was to be replaced with a far more questioning attitude towards their behaviours and practices. I had witnessed and indulged in conduct which I was later ashamed of and was determined not to repeat or allow to be repeated.

My concerns became more focused on the needs and rights of people with learning disabilities and towards creating an environment in which these could be best met and maintained. As such I regarded the Castle as anachronistic and many of its practices and personnel corrupt. However at this point in the late 1970s it was also obvious that institutional care of this group had suffered and was suffering from gross and chronic lack of provision and recognition. Many attempts at progressive measures from well-motivated and far-sighted staff and management seemed to be met with indifference from higher levels. There was a feeling of powerlessness among the nursing staff together with a perception that there was little understanding or appreciation of their work. National press coverage of conditions and criticism of several incidents at Lennox Castle had created a poor image of the institution. Staff in the hospital felt they were more aware than anyone else of the shortcomings but were unable to change them. A group of workers who were suspicious of comment or criticism from outsiders was the result. They reasoned that only those who worked in the place could understand it.

I left with a great deal of ambivalence. I felt that perhaps the only solution to the problems of the hospital would be closure and relocation of the residents. But there remained with me a large degree of affection and respect for many of the nurses and patients. I
particularly had a lot of time for some of the older men and women who had worked there for a long number of years. Their attitudes by the standards of the time were certainly out of date but this was understandable, coming from a very different era, and some of their stories about 'the old days' in the hospital were fascinating and illuminating.

Research strategy

As an undergraduate I was familiar with the work of Paul Thompson and Trevor Lummis and was attracted to the concept of oral history providing a forum for the voices of people who had been neglected, disadvantaged or discriminated against. For postgraduate research I considered concentrating on patients who had lived in long-term institutional care, a group whose voices had rarely been heard. However, several depictions of life within these hospitals which I read all portrayed the patients as victims and the nursing staff as perpetrators of various forms of abuse and neglect. I recognized these depictions as being truthful and accurate for I had witnessed similar actions. I also knew that the total truth was not being represented. While I myself felt critical of the actions of many nursing staff and the whole concept of institutional care for those with learning disabilities, I still experienced a residual defensive stance to criticism from outsiders 'who don't understand'.

Nursing staff were seen as perpetrators but they also suffered from a lack of representation and voice. The patients were seen as victims but the nurses were in many ways victims also: victims of established practices, difficult conditions and a powerful medical presence. I did not want to be in any way an apologist for those who practised mistreatment but I did want to encompass some kind of balanced account and explore the understanding that both groups had of their experiences.

By concentrating on the relationship between the patients and the nurses and researching and analysing the factors which made up their separate but parallel communities and cultures I hoped to illuminate what I believe to be the core of life in the institution: the interface between the two groups. This would hopefully lend some understanding to the nature of this particular institution, and to institutions for people with learning disabilities in general.

As can be seen, I was very intimate with and emotionally attached to my area of research. This gave me many worries as to the value of the work I was doing. Was it 'real' research? Was I in some way cheating by having all this pre-knowledge and therefore pre-judgement? And how could I represent the involvement that I had experienced? Would I just ignore it and present my data and analysis
from an outsider’s standpoint like a proper researcher? These thoughts all clouded my early work but I got on with the task of my research processes and put these awkward bits to the side.

**Insider advantages**

While the theoretical concepts of being an insider continued to cause me angst, I was experiencing some practical advantages. I was not coming cold to the subject of learning difficulties in general and had a fair knowledge of their history and related social, medical and parliamentary milestones and watersheds, and so had a fair start in background reading. Researching the local environment was also helped by the fact that I had known the librarian in Lennoxtown for a long number of years.

Possibly the area where I was most at an advantage was with informants. I started interviewing nurses whom I had known when I worked in the hospital and who were retired. I simply phoned them up, told them what I was doing and asked if I could interview them. With this group I was always made very welcome. Another set of people I interviewed were those who had worked at Lennox Castle at the same time as myself, were retired but who did not know me. I turned up at their doors and explained who I was and that I had worked in the hospital at the same time as them and again, they were all very cooperative. A third group were those who had retired before I started work and whom I did not know. They were suggested by some of the other informants. Again I knocked at their doors and explained what I was doing and told them who I was personally as well as professionally, i.e. who my mother and granny were. They were all familiar with my family, who had lived in Lennoxtown for generations. These work and family familiarities certainly eased my way into people’s homes to record and set up an initial trust in me. I do not suggest that it would have been impossible for an outsider to record some of these people, but I am fairly sure that some others would not have cooperated at all. Latterly, as word circulated in the community, I was being approached in pubs by nursing staff and offered interviews.

To interview people with learning disabilities, I started in a community unit in Glasgow where ex-residents from Lennox Castle were living. I knew the nurse who was manager there personally. After obtaining consent from any relatives through the unit, I visited the residents, most of whom I knew and who knew me, and recorded the interviews on videotape.

It was only at this stage that I contacted Lennox Castle Hospital itself and asked to interview residents there and have access to documentary material. I had been reluctant to do this initially as I anticipated a rejection, probably based on my perceptions of the
institution from the past. I could not have been more wrong. The hospital manager had been my immediate line manager when I worked there and he was enthusiastic and helpful. The management team and medical consultants gave me permission to interview, within the wards, residents and staff, providing they consented of course. I was also given access to hospital documentation and ledgers which were kept on site and various old documents and artefacts which were offered by various individuals. There was an obvious interest in the work that I was doing from the manager and various other staff, based, I think, on the fact that someone was acknowledging the institution and themselves as being of some social and historical significance.

Whether I would have encountered a similar attitude had I not been known, I am not sure. I suspect that there was a large degree of personal trust shown again. I should probably ask. When the manager retired he was succeeded by another acquaintance who had been brought up round the corner from me and she was equally cooperative and interested in the research. [...] Probably the least I can conclude is that the accommodating and supportive climate I encountered from the hospital management was partly due to my insider status and that this certainly eased and simplified my work. As an academic attached to a university, in pursuit of a legitimate research topic, I had been granted access to Greater Glasgow Health Board archives and would have expected access to any local archive material as well, but assistance, thankfully went far beyond that.

This was well illustrated when I attempted to seek permission to interview Margaret Scally. She was living in a community house after leaving Lennox Castle and the suspicion, obstruction and lack of help I initially encountered from the management of the agency responsible for her residence, brought home the difficulties that an outsider might experience.

Nursing is a profession, like others such as medicine, law or the police force, where confidentiality is instilled as part of the training and carried on in day-to-day work. Institutions for people with learning disabilities were held in very low esteem, particularly Lennox Castle which had generated criticism from many areas. People who worked there were touchy. These factors may have provided a barrier first of all to access to a nurse informant and secondly within the interview itself if there had been no shared background. I was able to gain rapport and trust through many shared factors: community, class, workplace, language – not only dialect but the language of the hospital – and certain attitudes. I was able to interview people in their own homes, which is usually conductive to a more relaxing and rewarding encounter. The questions I asked within fairly open-style interviews would be relevant, informed and sensitive given my familiarity with the subject.
When interviewing informants with learning difficulties, again I knew many of them personally from the past. I knew something of their day-to-day lives, environment, habits, preoccupations and sensitivities and the network of peers and members of staff who they were familiar with. I was used to talking to and interacting with people with disabilities, some of whom present special problems in communication and temperament. Some were shy and some were overbearing but they all, apart from one, were aware of the background that I shared with them.

**Insider disadvantages**

Trust opened many doors for me as an insider. People trusted me as one of them, from the hospital management to the nursing informants. They welcomed me into their homes and workplaces partly because they knew me or my background and had confidence in me. This was a double-edged sword. What did they trust me to do and did I have a duty towards them because they had shown trust in and friendliness towards me? Would this influence me to present my data and draw conclusions in a more sympathetic manner, first of all because it was expected of me and secondly because I was aware that many of my informants wanted to read what I wrote?

My data, however, had been influenced by my insider status from the beginning. I selected who I was going to interview according to my preconceptions and contacts and while I was attempting to portray a representative cross-section of the nursing community over time there is no doubt I could have obtained a very different picture by interviewing different personnel.

While I may have gained initial rapport in my interviews and felt confident in directing informants into relevant areas, these had their downsides also. There is always a danger that an informant will fill in little detail of a subject or incident if they are aware the interviewer has similar knowledge. I found this most prevalent in trying to establish the daily routines of the nurses who usually started off describing this fine then soon said something like, ‘Och you’ll know yourself.’ There were also many times, on reflection, when I did not ask for more detail when I should have, as I knew about what was being described or alluded to, but most would not. Perhaps sometimes I was so confident about the facets that I wanted to touch on that I did not allow the interviewee to establish the things that were most important to him or her.

Similar critical points can be made about my interviews with residents and ex-residents of Lennox Castle but further, there is the factor of my nurse-patient relationship with them. As mentioned above, many had known me in the role of nurse and all of the others except
one were aware of my status. This must have influenced them in their contributions in the interviews. I would certainly have been perceived as a representative of established authority and, given the effects of years of institutionalization, their conversations might have been quite different with someone without my connotations. This factor may be partly responsible for the fact that the most free and lurid criticism of the hospital and nurses that I recorded was from an ex-patient who did not seem to grasp that I had worked there myself.

Ethical considerations

I first interviewed three residents in one ward in Lennox Castle and went to the duty room to thank the nursing staff and say goodbye. Unexpectedly they had laid out the three sets of case notes for me to read and left me to it. I did read them and was impressed by the corroboration of accuracy of incidents and dates mentioned in the interviews. However this raised the question of whether I should make any use of the material in these notes that were available to me. Reasoning that the relationship I had formed with these people with learning difficulties as a researcher and interviewer would be challenged if I did this, I decided against it. I felt I would be going behind their backs. I also had no similar recourse to check on any of the nurses I had interviewed. This may have been poor research verification technique but I was certainly happier that way.

I also felt some uncertainty over the issue of informed consent. I had gone through ‘the proper channels’ in my interviews with ex- and current residents of the hospital, but many of the group were so used to accommodating requests from authority figures that there could hardly have been any refusal.

I was not particularly comfortable that some of my nurse informants wanted to and would read what I had written about them and the hospital. This was ameliorated by the knowledge that at least they would experience something tangible in return for giving their time and experience even if they might disagree with the picture I had painted and the conclusions I came to. However, the same could not be said for those with learning difficulties whom I had interviewed. I questioned if I was exploiting them and my position, as it is so easy to do, and offering them nothing in return.

Theoretical framework

When I began research work I could not have contemplated writing the above. I would have regarded these issues as subjective, unscientific, peripheral and self-indulgent. However, along the way I did manage to discover methodological frameworks and theories which
allowed me to address concerns which I initially felt would cloud and restrict the subject. In fact a burgeoning literature on the relationships between researcher and researched has placed this dynamic at the centre of the research process and raises many theoretical and ethical questions.

Facts and data are seen as only one half of a complete picture and ‘the other half – how ethnography comes about as a process of perception and writing – deserves to be analysed’ (Lonnqvist, 1990: 22). The ‘self’ has been recognized as the research instrument, dictating which research problem to tackle, which framework to utilize, what informants to give emphasis to and, as such, what goes on inside the researcher has become of the utmost importance.

The ‘self’ may be ‘simultaneously enabling and disabling’ [. . . ] but this means we have two good reasons for paying it due attention rather than dismissing it as an unfortunate, complicating factor in our work. In any case, since we cannot shed the self, we must give it a focal point in our writings. (Crick, 1992: 175)

An awareness of who reads what we write is also to the forefront. No longer can the audience be considered as fellow academics and both the subjects we research and the press have to be considered as readers, and readers who will have a reaction.

The authors collectively ask us to re-evaluate the viability of a distinction between ‘insider’ and ‘outsider.’ They examine further the issues of ethnographic authority and the politics of representation, and demonstrate how they personally have dealt with the challenges to authority and interpretation that they have faced either during the process of field work or after the publication of the results of their research. (Brettell, 1993: 22)

Different forms of research text have also been explored and cooperative manuscripts, written by informants and researchers together, are a variation on the conventional productions. I might have attempted this with some of the interviewees with learning disabilities, had I been familiar with the concept at the time, to allow them to experience some autonomy and return.

Conclusion

The fact that I was so much an insider initially gave me great problems in my approach to the research, although I recognized certain advantages and disadvantages which it generated. One of the biggest disadvantages which I perceived initially was how to communicate my own past experiences and address their effect on my research processes. I came to understand that, far from being a confusing problem, the discussion of my status as an insider should be
central to any analysis and that this lent clarity rather than confusion to my work.

References

