

# The Impact of Qualitative Research on the “Real World”: Knowledge Translation as Education, Policy, Clinical Training, and Clinical Practice

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## Abstract

Knowledge translation (KT) remains an elusive term that has no unified definition in the health or social sciences. The wide scope of what KT is in practice invites creativity in disseminating research findings. In this article, we describe innovative KT initiatives based on different methodologies of qualitative research we conducted in the fields of psycho-oncology and mental health. These include medical and public education, training mental health clinicians, national policy recommendations, and clinical interventions in the health field. As academic researchers, we bear a responsibility to the public we are intended to serve with our qualitative research. We argue that researchers need to take KT seriously and think deeply about not only what we research but also the ways in which we translate that knowledge to make the maximum possible positive impact on the communities we study and serve.

## Keywords

qualitative methods, psychology, knowledge translation, academy

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Historically, academics were charged with the role of being the public intellectuals of society (Bender, 1997). That is, the role of the academic was to procure research that could inform societal needs and serve the culture in which they lived. Their value was in direct proportion to their ability to be useful and educated public servants. As academia has become increasingly more corporatized in recent decades, the institutional and personal expectations have shifted. Modern academics in industrialized societies today are primarily expected to bring in as much money as possible to the university through grants and to publish as much research as possible in high-impact journals (Riggs, 2013).

In the past decade, the tides have begun to turn again and more emphasis has been placed on what has broadly been called knowledge translation (KT; Davis et al., 2003; Lavis, 2006; Sandelowski & Leeman, 2012; Tetroe et al., 2008; Woolf, 2008). This is especially true in the health and psychological sciences, where research funding frequently comes from taxpayer money and where there is an expectation that this investment will serve the public. Despite the recent emphasis on KT, it is an ambiguous term that has no unified definition in the health or social sciences. One qualitative study that interviewed participants working in health research funding agencies in North America and European countries found that KT was defined in 29 different ways. Examples of KT definitions included “capacity building,” “diffusion,” “dissemination,” “impact,” “knowledge communication,” “translation,” and so on (Tetroe et al., 2008). The simplest and broadest definition of KT comes from the basic sciences literature that defines KT as “translating research into practice” (Woolf, 2008, p. 211). However, what is meant by “translation” and “practice” can vary among different researchers. Moreover, KT initiatives can include a wide range of activities such as academic publications, media outreach, informational webpages on the Internet, clinical interventions, use of the arts to disseminate data, workshops for academics or the public, conferences, policy briefs, and so forth (Lavis, 2006; Tetroe et al., 2008).

The wide scope of what KT is and looks like in practice can be challenging to grasp for academics, but it also leaves an open space for creativity in disseminating research findings. In this article, we describe several of our projects that have had an impact in the “real world.” By “real world,” we mean that this qualitative research has in some capacity affected people outside of readers of academic journals or academic conferences. Massey and Barreras (2013) have called this type of research the kind that has “impact validity.” Impact validity has to do with the extent to which research findings translate, engage, and affect the public in service of a social or political good. In their definition, they note that impact is more than simply the production of data

and that KT and community engagement are key aspects of the research process (Massey & Barreras, 2013).

Our own KT initiatives fall into several domains including education, clinical training and practice, and mental health policy. For each of these domains, we begin by describing one research project by briefly summarizing the findings and then illustrate the KT initiatives that resulted from these qualitative studies. The first study we describe is a qualitative research project that examined the grief of oncologists when their patients died (Granek, Krzyzanowska, Tozer, & Mazzotta, 2012; Granek, Krzyzanowska, Tozer, & Mazzotta, 2013; Granek, Mazzotta, Tozer, & Krzyzanowska, 2012; Granek, Mazzotta, Tozer, & Krzyzanowska, 2013; Granek, Tozer, Mazzotta, Ramjaun, & Krzyzanowska, 2012). KT for this study included medical and public education. The second study looked at mental health intake sessions to examine ways to improve culturally sensitive delivery of care (Alegria et al., 2008; Nakash & Alegria, 2013; Nakash, Dargouth, Gao, Oddo, & Alegria, 2009; Nakash, Nagar, & Levav, 2014; Nakash, Rosen, & Alegria, 2009; Rosen, Miller, Nakash, Halpern, & Alegria, 2012). The KT in this case involved the application of the research findings in clinical training of mental health clinicians and clinical psychology interns and national policy recommendations on providing culturally sensitive mental health care. Finally, the third project describes a set of studies that examined why women delay seeking medical care when they first find an ambiguous breast symptom (Fergus et al., 2011; Granek & Fergus, 2012; Granek, Fitzgerald, Fergus, Clemons, & Heisey, 2012; Heisey et al., 2011). In this final project, the KT initiatives involved clinical practice interventions.

With each of these studies and KT initiatives our intent is to illustrate that: (a) qualitative research is a powerful methodology that can have a significant impact in many social spheres and; (b) despite the fact that KT often fails to “count” in the traditional academic promotion criteria, it is an important aspect of the qualitative researchers’ work that requires further thought and consideration. We conclude our article by offering some practical suggestions on how other qualitative researchers can implement these KT initiatives in their own work.

### *Education Knowledge Translation*

*Oncologists Experiences of Patient Death.* Between 2010 and 2013, I (Granek) conducted several studies on the grief of adult oncologists in Ontario, Canada (Granek, Krzyzanowska, et al., 2012, 2013; Granek, Mazzotta, et al., 2012, 2013; Granek, Tozer, et al., 2012). While previous research had looked at the grief of health care professionals in general (e.g., nurses, general physicians,

etc.), no previous studies had examined oncologists' grief specifically, and none had used qualitative methodology in the study design. The study of adult-focused oncologists utilized the grounded theory method to collect and analyze data on 20 oncologists working in Canadian medical academic centers. My (LG) research found that Canadian oncologists' grief was a unique affective mourning experience, resulting in feelings of self-doubt, guilt, failure, powerlessness, and sadness, and in sleep loss and crying. The impact of patient deaths on the oncologists was manifested in burnout, compartmentalization, emotional exhaustion, and difficulties in maintaining emotional boundaries. The impact of the oncologists' grief on their patients found expression in their focus on active treatment (e.g., aggressive chemotherapy, clinical trials, etc.), instead of an end-of-life care, including their reluctance to refer patients to palliative care, their distancing themselves from dying patients, and their heightened motivation to improve care for their other patients. I found that oncologists also experienced grief spillover—taking grief home with them—which had a negative impact on personal relationships with family and friends. My research thus indicated that grief has an impact on oncologists' well-being, on physician–patient relationships, and on patient outcomes (Granek, Krzyzanowska, et al., 2012, 2013; Granek, Mazzotta, et al., 2012, 2013; Granek, Tozer, et al., 2012). Of greatest significance to oncology and to the health care system is that some of the oncologists' reactions to grief reported in this study (e.g., treatment decisions, distraction and withdrawal from patients, etc.) suggest that the failure of oncologists to deal appropriately with grief over patient loss negatively affects their personal lives and might also negatively affect the lives of their patients and their families. In addition, I found that Canadian oncologists' expressions of grief were indeed a reflection of North American culture, where death, dying, grief, and loss are considered stigmatized and taboo topics, leading some Canadian oncologists to be uncomfortable with discussing death, dying, and end-of-life care with dying patients.

### *Medical Education as Knowledge Translation*

The classic approach to medical education is to publish articles in medical journals that are read by physicians. This is one of the primary routes to academic KT, but was insufficient for the type of impact I wished to have with this research on oncologists' experiences of patient death. I published the articles in medical journals (Granek, Krzyzanowska, et al., 2012, 2013; Granek, Mazzotta, et al., 2012, 2013; Granek, Tozer, et al., 2012), but used a number of additional pedagogical strategies as part of my KT plan. As university educator, my philosophy is that of “embodied pedagogy” (Granek,

2010)—that is, I believe that education that is taken to heart and truly practiced must be learned in relationship with others and in forums where there are opportunities to self-reflect. As such, my KT practices began by offering to “give back” the research findings to the participants by giving talks at each of the hospital sites I had initially recruited at. As a result of the first talk, I was invited to give more than a dozen Grand Round presentations on the topic to oncologists and other health care professionals working in the field at hospitals in Canada and the United States.

The Grand Rounds typically were an hour to an hour and a half in length and included a presentation of the findings and ample time at the end of for a discussion and questions. The audience comprised a range of health care practitioners including oncologists, nurses, fellows, psychologists, psychiatrists, palliative care doctors, hospice workers, family doctors, and clergy. In addition to the rounds, I also began a series of workshops for oncology fellows that were 4 hours in length and that integrated research from the field, my own study findings, and a guided discussion on the challenges of being an oncology fellow in the context of end-of-life care (see Granek et al., in press). Each of the presentations of this research began and ended with a series of self-reflective questions for the audience, which included prompts such as:

Please think of one patient who died that was particularly difficult for you. How did you feel when they died? How long did you feel that way? How did you feel about your own reaction? Who, if at all, did you talk to about how you were feeling?

At the end of the talks, I opened up the floor by asking the audience to think about their own reactions, thoughts, and feelings to what I had presented. I asked if there was anything they could relate or not relate to, and if anything surprised them. Finally, I asked them to think about their own challenges in facing patient deaths and to discuss what they think they might need or want to help them deal with this aspect of their work.

While published articles are effective conduits of scientific knowledge, forums to discuss these issues were particularly powerful in translating this knowledge into practice. The feedback from the talks was positive and tended to focus almost entirely on the integration of this information into the health care professionals’ practice. Dr. Abha Gupta, for example, was interviewed on Canadian Broadcasting Company Radio about her reactions to one of the Grand Round sessions. She remarked:

Dr. Granek came and gave a session to our division. . . . I would have to say that 1 hour where she came to describe her study was probably the most therapeutic

hour of my entire career. She was able to say, in a very succinct way, in the context of a framework, everything that we feel on a day to day basis and no one had ever done that before.

In the context of KT of qualitative research into practice, the power of this statement is dual. In the first instance, it is a confirmation of a deep type of face validity that is an outcome of good qualitative health research. When Dr. Gupta remarked, “she was able to say in a very succinct way in the context of a framework everything we feel on a day to day basis and no one has ever done that before,” she is describing one of the primary purposes of qualitative research, which is to take experiences that have rarely been studied before across a number of participants and summarize it into a succinct framework or, in grounded theory terms, a succinct theory that captures the phenomenon for the participant. It is precisely because of the deep face validity of the research—the touching people personally with the research findings—that education and change can transpire. In the second instance, Dr. Gupta’s courage in speaking about a topic that tends to be taboo among oncologists on national radio opened up a conversation among physicians that had rarely been had before. The power of the Grand Rounds or the other educational forums in which this research was presented was that it allowed health care professionals to talk openly to each other, some for the first time about these issues.

One institution I spoke at sent out a survey to participants on these talks and confirmed Dr. Gupta’s experience as well as laid the ground work to future interventions (i.e., increase opportunities for safe discussion on the topic). Ninety-seven percent said the session was relevant to their work, 93% said they would attend a future session on this topic, 87% said the discussion gave them new insights into perspectives and experiences of colleagues, 83% said they gained new insights into their own experiences, 77% said they would feel more comfortable talking about their grief with colleagues after the talk, and 90% said it would be helpful to have more “safe spaces” to discuss these issues.

As part of the survey, participants were invited to reflect on the talk and make any comments they wished. One participant noted: “The seminar has helped give me permission to speak about this issue with others.” Another said,

I will proactively ask how my colleagues are dealing with the repercussions of patient death/loss in order to be a sounding board for them. I will be more open and less fearful to discuss these issue in a more public forum.

Finally, a third said, “I will have an open exchange about personal feelings and not feel like I have failed [when patients die].” As a result of these

studies, some hospitals in Canada and the United States have started to include a half-day workshop on the issue of dealing with patient death. In addition, I participated in a number of medical education initiatives to move this research into practice including participating in a *Journal of the Medical Association* podcast session on the work (Meyer, Granek, & Quill, 2012) and I did an interview for an article published in the *American Medical Student Association* magazine that provided pointers on how to cope with these issues in medical school.

### *Public Education as Knowledge Translation*

At some point along my research trajectory on this topic, I understood that while medical education was essential in making clinical changes with my research, it was not sufficient. I learned from my research that dealing with patient death was a quality of life issue for physicians in general, and that educating oncologists, or those who work in the oncology health care setting was only the first step in addressing this issue. It was important that patients and caregivers understood the complexity of dealing with patient death in the oncology setting. In each of my talks, and in all my published work, I make the point that the problem of coping with patient death is not the *individual oncologist's* issue to deal with, it is part of the *structure* of this work and it is a conversation that has to be had in a wider audience.

My first attempt to translate my research findings for the public was to write an accessible, nonjargon editorial for the *New York Times* about the findings from this study and its implications for medical practice (Granek, 2012). The readership for this newspaper is wide and reaches approximately 30 million people on the weekend either online or through subscriptions. The impact of this editorial on public education was larger than I could have anticipated. I received hundreds of e-mails in response from doctors, nurses, family members, medical students, and many family members who were grieving the losses of people, who died from illness, and who had negative experiences with doctors in the past. Each of these people from around the globe had something new and interesting to say about the topic, and many felt that this was the first time this issue was being addressed from both the physician side and the patient and caregivers perspective. *The New York Times* article had a snowball effect of putting this issue on the "map." It was subsequently covered in the *Toronto Star*, *The Boston Globe*, and *Readers Digest* among other newspaper and magazine outlets, and on Canadian and American radio where hosts posed the questions, "should medical schools offer grief training for doctors?" (Nath, Gupta, Laycock, Granek, & Francescutti, 2014; Scallan, 2012; Shen, 2012) and "can oncologists grieve?" (Galloway & Granek, 2012).

In terms of public education as a KT initiative, the impact of this media coverage is that it opened up a conversation that had not been had before in a public sphere. The raising of awareness and consciousness about this issue of physicians difficulty dealing with patient death was the education in of itself. Both the medical and public education initiatives described in this section are not one time KT projects that occur in a particular time and place. Rather, they have a reverberating effect in the culture, which can change the way we understand how medicine is practiced, who doctors are, what they need, and how patients relate to them.

### *Training and Policy Knowledge Translation*

*Mental Health Disparities in Clinical Psychology.* As a clinical psychologist in an increasingly global world, I (Nakash) have repeatedly come across a culturally diverse client population, but received limited knowledge and training on how to give culturally sensitive care that would address the unique needs of the people I saw for psychotherapy. Moreover, as a researcher, I am aware of the limited empirical research that exists to guide clinicians and to deepen our understanding of how sociocontextual factors influence diagnosis of mental illness and quality of mental health services to diverse populations. Traditionally, clinical research has not been conducted in collaboration with clinicians. This divide between research and practice has often resulted in a problematic atmosphere of mistrust between communities of researchers and clinicians, and the “ivory tower” studies that have little impact on everyday practices and KT.

To address some of these challenges, and help clinicians improve the quality and appropriateness of mental health services to culturally diverse populations, we needed to integrate a bottom-up cultural, anthropological approach. Such an approach allowed my research team and I to systematically collect information about individual differences and to consider their specific socio-cultural contexts. For example, in naturalistic settings, clinicians usually solicit information about the client’s main problem through questions such as: “what brought you to seek care?” The task is akin to an interpretative exercise in which the clinician must formulate and define “the problem” using incomplete data from reports and observations. As clinicians come in contact with an increasingly diverse client population, they are challenged to assess the impact of culture on all aspects of mental illness including the symptom presentation. In the project I (ON) detail below, my collaborators and I used qualitative methods to examine what information clinicians elicit and how they evaluate cultural and sociocontextual information during the therapeutic encounter. We were convinced that to ensure useful KT, we had

to do participatory research, in which clinicians in public settings would fully collaborate in the design of the research as well as analyses and interpretation of the data we collected.

With all of this in mind, we launched a large-scale mixed-methods naturalistic study. As part of this project, we conducted semistructured in-depth interviews with therapists and clients immediately following the mental health intake in community mental health clinics in the Northern United States (a total of 129 dyads were interviewed). The mental health intake is the first encounter between clients and therapists, and as such it forms the basis for mental health care. The challenges of the intake (e.g., establishing rapport, diagnosis, initial treatment planning) are amplified when cultural differences exist (Nakash, Rosen, et al., 2009; Rosen, Nakash, & Alegria, 2014). Cultural differences can include unfamiliarity and/or discomfort with a client's beliefs, practices, understanding of etiology, acceptable approaches of treatment, and communication style, all of which can create additional levels of complexity in the initial encounter (Nakash, Rosen, et al., 2009). The project, which resulted in several publications (Darghouth, Nakash, Miller, & Alegria, 2012; Nakash, Dargouth, et al., 2009; Nakash, Rosen, et al., 2009; Rosen et al., 2012) led to international collaboration and a follow-up research project in which we continued to investigate mechanisms contributing to mental health service disparities in a different system of care, such as in Israel, where I currently live (Nakash, Nagar, Danilovich, et al., 2014; Nakash, Nagar, & Levav, 2014, 2015). In this follow-up project in Israel, we conducted in-depth interviews with therapists and clients immediately following the mental health intake in community mental health clinics in three large cities in Israel (total of 125 dyads were interviewed). The semistructured interview protocols in both studies included questions about clients' and therapists' understanding of the presenting problem (i.e., why the person came to therapy), and the quality of the rapport and their views of the role of sociocultural factors in the presenting problem. We employed a phenomenological approach (Giorgi, 1997) and a thematic analysis (Braun & Clarke, 2006).

The analyses from both projects helped us identify specific challenges to deliver culturally competent mental health care as well as formulate specific recommendations to evidence-based best practices to work with culturally diverse populations. Findings, which are published elsewhere, focused on the process of clinicians' decision making (Nakash & Alegria, 2013) as well as processes that contribute to the development of good rapport between diverse clients and clinicians; both are critical elements of a successful intake visit. We were also interested in the client's preferred communication style and role of bias in the client-provider interaction (Nakash, Rosen, et al., 2009;

Rosen et al., 2012). For example, we found that therapists used intuitive processes to guide many decisions they made during the intake visit. Intuitive decisions in our case are decisions or “hunches” made without the conscious awareness of how they were made. The thematic analyses revealed the characteristics of intuitive processes. We learned that they were vital in allowing therapists to integrate multiple sources of information such as nonverbal and affective information. As such, they were an important tool in making decisions about how to relate to a certain patient and how to facilitate rapport. However, they were also potentially a source of bias as they can lead to incorrect diagnostic decisions if they alone serve as screeners for diagnosis (Nakash, Nagar, & Kanat-Maymon, in press).

### *Clinical Training and Policy Recommendations at Knowledge Translation*

The depth and richness of the qualitative interviews with clients and therapists as well as the systematic analysis utilizing rigorous thematic methods allowed us to develop guidelines for culturally sensitive delivery of care, focusing on the mental health intake. For example, our guidelines included recommendations on educating mental health professionals and trainees about the role of intuition in their decisions. The goals of these recommendations were to reduce the possibility that intuition will guide them in making decisions that should be based on explicit assessment rather than on implicit impressions. This is important to reduce bias and inaccurate diagnostic decisions that occur more frequently with clients who are ethnic minorities.

The interviews themselves initiated a dynamic dialogue between the researchers and the clinicians that has previously been missing in traditional research and is imperative for effective KT. As a result of these dynamic discussions, we developed policy, training, and practice recommendations. We presented these recommendations in a series of workshops to practicing clinicians in mental health clinics in the United States and in Israel as well as clinicians in training (e.g., national workshop to psychology interns in Israel). The workshops involved experiential elements as well as presentation of specific findings about challenges and possible solutions to deliver culturally sensitive care. Being able to present vignettes and excerpts from the interviews in the clients' and therapists' own words was one of the most powerful elements of these trainings. We often received the feedback that therapists believed they were alone in their everyday struggles with the clinical and ethical dilemmas arising in the cross-cultural clinical encounter (i.e., how to balance attunement to culturally normative behaviors and the medically dictated discourse of diagnostic systems).

Through presentation of dilemmas clinicians described during real-life intake sessions in the study, clinicians in the workshops remarked: (a) the material was highly relevant to their practice; (b) they were not alone in struggling to manage these complexities, thus contributing to dynamic dialogue and a sense of community around issues revolving culturally competent care; and (c) they can have evidence-based tools to manage some of these challenges (i.e., explicitly asking clients what their preferred communication style is rather than wrongly assuming that clients, particularly of specific ethnicities, are not cooperative and/or poor narrators).

The developing relationship and growing sense of trust between the researchers and the clinicians contributed to the integration of the research findings in the practice for conducting culturally sensitive intake in several mental health clinics. For example, in two clinics in Israel, we developed and implemented together with the directors of training a course on culturally competent care that emphasized many of the guidelines, we developed as part of the study, as well as adaptation of the intake forms. Some of the clinics adopted the recommendation to include questions about ethnic/cultural background of clients as well as explicitly asking about expectations from care. We also developed a mandatory course on culturally competent evaluations in mental health care for a graduate program in clinical psychology in one of the higher education institutions in Israel. The course included both scenarios and vignettes from the interviews in the study in which clinicians or clients discussed the possible effects of the sociocultural background on interpretation of mental health symptoms or preferred care. The vignettes helped build the missing bridge between science and practice and better prepare the students to the “real-life” dilemmas they might encounter in their future practice.

Finally, the growing impact of the findings to improve care, and the development of evidence-based practice guidelines to conduct culturally sensitive evaluations led to the development of a successful collaboration with the Israeli Ministry of Health. The ministry adopted in 2011, a policy to reduce inequalities resulting from ethnic and social class disparities and called for research to develop to evidence-based knowledge to adapt services to culturally diverse groups. As part of this collaboration, together with a multidisciplinary team (including researchers and clinicians), we developed a cultural competence training program for mental health professionals. The 2-year training program focuses on the sociocultural context of delivering mental health care and integrates many of the findings of the projects on conducting culturally sensitive intake and mental health evaluations. These examples demonstrate the innovative KT strategies of implementing findings from qualitative research in clinical training of graduate students, practicing clinicians, and policy makers.

## *Clinical Knowledge Translation*

*Women's Decision Making Around Seeking Care for Ambiguous Breast Symptoms.* When I was a postdoctoral fellow (2009-2011), I (Granek) worked on a series of studies on how women make decisions around seeking medical care when they first find an ambiguous breast symptom. In the first study, we interviewed women and their romantic partners separately about this decision-making process and used a grounded theory analysis (Fergus et al., 2011). We then did a secondary analysis on the data using a discourse analysis (Granek & Fergus, 2012). In the first analysis, we found that the spouse's role was limited in women's decision-making processes around seeking care. In the article, we provided a detailed explanation about the individual psychological and emotional trajectory women go through when making these types of health care decisions (Fergus et al., 2011).

In the second reading of the data, we used a discourse analysis. We wanted to examine the social and cultural discourses around which women make decisions to seek medical care for breast symptoms that moved beyond the individual psychological trajectory described in the first article. We found that the dominant medical discourse for women allows for two socially acceptable explanatory narratives around seeking help for a breast symptom. The first was that the woman was unaware of her symptom, or interpreted it as being insignificant, and therefore, did not think it required medical attention and as such, did not go to the doctor. The second option is that the woman noticed her symptom, interpreted it as potentially dangerous, and immediately sought medical attention. The one possibility that is unavailable in these discourses is that the woman was aware of her symptom, recognized that it might be medically threatening, and chose not to seek care immediately. Many of the women in our study fell into the third category, but because it was not a culturally acceptable narrative to admit that they knew the symptom might be serious and did not seek help, they engaged in a back- and forth-oscillation between "knowing" and "not knowing" the symptom was there (Granek & Fergus, 2012).

In the second study, we interviewed women who had delayed seeking care for an ambiguous breast symptom for at least 3 months, and family doctors about why they thought women delayed seeking medical care. In the Canadian health care context where the studies took place, family doctors are responsible for referring women to oncologists if needed, and as such, we thought it was particularly important to interview them about their reflections on why they think women delay in coming to them when they are concerned about a breast symptom. In the first reading of the data, we used a thematic analysis (Heisey et al., 2011) and in the second reading of the data, we used a narrative analytic lens (Granek, Fitzgerald, et al., 2012). One of the major findings

from the narrative analysis component of the research was that women who had a previous history with hard to diagnose conditions such as fibromyalgia, chronic fatigue syndrome, chronic pain, and irritable bowel syndrome tended to have negative experiences with doctors who were dismissive of them in the past. Sometimes this frustration with diagnosis and the way they were treated in the medical system caused them to delay going to their family doctors several decades later for something completely different such as breast lump. Our findings also revealed that some women had experienced doctors as being pathologizing and judgmental in the past.

Indeed, the reasons women talked about delay and the reasons family doctors talked about delay were not always aligned. Women tended to talk about: feeling dismissed in the past, having hard to diagnose conditions, reproductive and pregnancy-related issues, and cultural stigma around breast cancer. Doctors focused on the women's addiction history and shame around substance abuse, the women's fatalistic thinking, the women's mental health issues and personality traits, the women's guilt around health care behavior, and their histories of childhood sexual abuse. Thus, whereas women focused more on health care system issues, on cultural issues, and on family issues, doctors tended to focus on pathologizing and individual characteristic issues like mental health pathology and substance abuse.

### *Clinical Implications as Knowledge Translation*

As a health psychologist, one of the aspects of qualitative research I (Granek) most appreciate is the potential it has to shed light on complex medical interactions and decisions that quantitative research cannot address. These studies on decision-making processes and delay gave us deep insight into the clinical practice implications. In situations like these, where medical compliance and decision making is the main concern, interventions, which are often based on quantitative research, do not address the underlying complexity of patient's decision-making processes. Even when the structures are in place to support patients (e.g., doctors available, medicine is accessible, etc.), often patients still make decisions based on other complex, often psychological or emotional factors. Good qualitative research excels at addressing these underlying issues and recommending clinical implications that get to the heart of the matter.

KT in the case of these qualitative studies involved changes to clinical practice in the health care system. In terms of clinical implications, our thematic research showed us that for women, sometimes frustration with diagnosis and the way they were treated in the medical system caused them to delay going to their family doctors many years later for something different like an ambiguous breast lump. Therefore, one of the clinical implications we

recommended is that on the general family doctor intake form, a question is added that targets women's previous experiences with the health care system, with a particular focus on negative experiences that can be affecting present behavior (Heisey et al., 2011).

Another clinical implication included alerting doctors about the importance of good communication and building trusting relationships with their female patients. This conclusion came out of our narrative analysis that illuminated the stark contrast between patients and physicians when it came to explaining delay behavior (Granek, Fitzgerald, et al., 2012).

As with the initiatives discussed in the previous sections in the context of KT, these medical clinical recommendations are not just about *one* intervention, but rather, about changing the way physicians think and act toward their patients, particularly in sensitive instances around compliance and medical decision making. Our research resulted in a number of recommendations, which were couched in the complexity of both psychosocial and societal influences when it comes to decision-making processes around health care. Although only some of these clinical recommendations have currently moved into practice (e.g., the family doctor intake sheet), all of these clinical implications have been proposed and recommended as actionable interventions in the health care context. While we acknowledge that knowledge transfer from qualitative research takes time and persistent petitioning of key administrators, we include these implications here to illustrate the significant types of KT initiatives that can emerge in clinical care settings out of rigorous qualitative research. These KT initiatives include the following: (a) highlighting the micro and macro understandings of medical decisions. For example, illuminating the personal psychological trajectory of seeking care for ambiguous breast symptoms versus the societal gendered pressures/expectations on women's bodies that influence decision making; (b) compassionate understanding of difficult medical decisions. For example, highlighting physician pathologizing and judgment versus subjective perceptions and subjective logic in delaying seeking care; and (c) formulating evidence-based, contextually appropriate interventions that work. For example, raising awareness about implicit/explicit judgments of physicians, changing intake forms to include relevant questions that encourage preventative care, providing medical education that deals with macro-level assumptions and that have micro-level impacts, and tailoring interventions for specific populations and needs.

## Discussion

In this article, we have described a number of innovative KT initiatives in the domains of medical and public education, training of mental health

clinicians, national policy recommendations, and clinical interventions in the health field. Each study we described used a number of different types of qualitative methods and each had a significant impact that we believed served the public good. In concluding this article, we would like to turn our attention to why KT is an important part of any research agenda, and in particular, in the health sciences, while also taking into account the current academic climate where the emphasis is on productivity as measured by number of publications and grants.

We noted in the introduction that there has been an increasing interest in integrating KT in academia. For example, most researchers are now required to include a KT component in their grants and/or include a recommendations section at the conclusion of their manuscripts (Riggs, 2013). Whereas these are commendable first steps in increasing the usefulness of our research findings for the public, the reality, as most academics know, is that the emphasis on KT is often just lip service. The pressure on academics, particularly early career, pre-tenure ones such as ourselves is to publish in academic journals, stay out of “politics,” and bring in as much grant money as possible. Some universities frown on academics who spend too much time speaking to the public through the media, or who do extensive work in communities (Riggs, 2013). These activities can be perceived as “activism,” and thus, political, unserious, or unscientific.

KT is also time consuming and demanding, and is a particularly difficult endeavor in the social sciences, where research can be theoretical and more difficult to translate into practice than in the health sciences. Moreover, writing and speaking to the media, writing for, and talking to policy makers, and training mental health professionals or physicians requires a specialized skill set that academics rarely receive training for in a graduate school. Given that KT is often dismissed by the people who “count”—those that give promotions and grant tenure, and given that good KT initiatives take time, thought, and energy on the part of the researcher, why do it at all? Moreover, what are some practical strategies to develop KT initiatives in the current academic context?

### *Why do Knowledge Translation?*

In thinking about the question of *why* do KT, we would like to return to the notion of the role of the public intellectual we opened this article with. In 1967, Noam Chomsky wrote a searing article for *The New York Review of Books* about the role of academics in the Vietnam War. In it, he argued that academics’ research, knowledge, and expertise can be used to achieve political and social aims for good and for bad. In this essay, he lambasted academics for remaining silent about the Vietnam War, or worse, for using their

science to promote and justify further military action. The responsibility of the intellectual, he argued, was to “speak the truth and to expose lies.”

More recently, Massey and Barreras (2013) have stated, “the misuse, marginalization and politicization of research is the norm rather than exception” (p. 615). For example, the misuse of research findings to further political agendas has been noted by Fine (2012), who argued that research evidence in the psychological sciences is often used to justify further marginalization of poor women of color by providing “scientific proof” that structural supports (e.g., prison rehabilitation, welfare programs, etc.) are ineffective. Moreover, researchers who work on social issues in the mental health or health domain are often frustrated with the enormous gap between research evidence and actual health policies affect people’s day-to-day lives as well as the gap between research and practice (Lavis, 2006; Mangione-Smith et al., 2007; Massey & Barreras, 2013; McGlynn et al., 2003; Sandelowski & Leeman, 2012).

In agreement with these authors that all research is political and in agreement with the complexity and concern of how research can be used in the public domain, our answer to the question of why do KT, is that as academic researchers, we bear a responsibility to the public we are intended to serve. We are responsible in making sure: (a) that first and foremost, we are producing research that is useful and not causing implicit or explicit harm to any of the populations we study; (b) that our research is not misused by ourselves or others to further a potentially harmful social and political agenda; and finally (c) that we are wholly responsible for bringing the message of our research forward in the most effective way possible to serve the public good.

For each of us “public good” means something different. For Granek, for example, the right to a pain-free and dignified death, and the desire for a more relational, emotional, and human encounter in medicine is part of the motivation to research oncologists and to talk to them directly through workshops and through the media. For Nakash, the right to a therapeutic encounter that is culturally sensitive and free of racist assumptions is of paramount importance. These beliefs are implemented through the education initiatives, training programs, and policy recommendations that emerged from a rigorous set of qualitative research studies we described throughout this article. Although our research agendas are different, we are both motivated and guided by our values and a belief that our qualitative research projects and the KT initiatives that come out of them can play a small, but important part in making the world more just and humane.

### *How to Do Knowledge Translation in the Current Academic Context*

As junior academics in vulnerable (i.e., pre-tenure) positions, we are well aware of the fact that it is easier to answer the question of *why* do KT than

*how* to do KT given the very real academic constraints. As we have noted throughout, the reality of a neoliberal academic climate (Cote & Allaha, 2011; Giroux, 2002; Slaughter & Rhoades, 2009) that rewards publications and grants at the expense of the time and energy spent on the other kinds of KT initiatives described in this article cannot be ignored. We work in a particular sociopolitical context that values some kinds of knowledge over others. Many academics, particularly those that conduct participatory action research, have addressed this dilemma extensively in other published work and we direct the reader to this canon for further reading (Fine, 2006; Lykes, 2001; Lykes & Crosby, 2014; Payton, 1984; Ponic, Reid, & Frisby, 2010). Personally, we do not have easy answers to this dilemma. In the spirit of reflexivity, we acknowledge that our own KT initiatives have not “counted” toward our academic promotions. We knew that this would be the case, but we choose to do them anyway because we care about the people we work with and we want to—and feel responsible toward—making their world a better place as they have made our own worlds richer and fuller by their participation in our projects. Given this qualifier, we can offer only our own modest suggestions that have worked for us with the acknowledgement that these strategies may not help with academic promotion. Some of our approaches have included taking a media-training course, where we learned how to concisely speak to the point in media interviews and the general structure of an editorial in a newspaper (i.e., word count, editorial formula, etc.; see American College of Emergency Physicians, 2014; Duke University’s Office of News and Communications, 2013). In addition, we have sought out and participated in training that has taught us how to write policy briefs from our research (see The Women’s and Children’s Health Policy Center, 2014). Last, and most important, we have learned with experience that the best KT initiatives happen in research communities where relationships and mutual trust and respect have been built over time resulting in genuine care and concern for the participants and their lives (see Chataway, 2002; Christopher, Watts, McCormick, & Young, 2008).

In conclusion, the pressure to attain tenure and the concurrent need to publish constantly and write grants nonstop can skew our understanding of why we do research in the first place. It is of utmost importance to remember that the bottom line is not whether we publish our articles in high-impact journals, attain the most grant money in the department, or even if we ultimately achieve tenure. The bottom line is that our research should be of service to the populations that we study. To achieve that goal, we need to take KT seriously and think deeply about not only what we research but also the ways in which we translate that knowledge to make the maximum possible positive impact on our respective worlds.

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