A Methodological and Practical Guide to Study Peripheral Voices in Qualitative Research

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Abstract
The selection of the voices that make up a qualitative research project is of great importance since the knowledge gained about a certain object of study depends on it. Qualitative researchers focus on the voices around which the purposes of their research explicitly revolve. However, they do not customarily pay attention to peripheral voices, which are primordial to understanding the complexity of the phenomenon studied. In this article, we fill in the literature gap regarding the inclusion of peripheral voices as participants in qualitative research. We develop a five-stage methodological and practical guide to identify who the peripheral voices are, how to plan their approach, how to listen to them and how to analyze their narratives. We illustrate its practical application using the results of doctoral research focused on the construction of the nurse’s status in healthcare organizations. We conclude by discussing the potential of their inclusion in qualitative research.

Keywords
qualitative research, voice hearing, peripheral voices, methodological guide, health care, nursing

Introduction
Numerous qualitative researchers center on understanding and explaining phenomena giving a voice to those individuals who by economic, cultural, and political dispositions have traditionally been silenced, not recognized as peers in social life and unjustly excluded from it (Denzin & Lincoln, 2017). These individuals become the central voices of a research project. That is, the vulnerable, precarious, oppressed or disqualified voices on which researchers focus their attention and interest, which are decidedly amplified through activism and social advocacy, and from which researchers mean to produce new knowledge aimed at liberation from oppression, social emancipation and the construction of a fairer society. This reflects the political and epistemological value of placing them at the center of research (Fine & Vanderslice, 1992).

The central voices are not alone in the meanings they attribute to the representations they make of their realities. They are projected and presented to the researcher as (co) constructed by meanings, discourses, affections, spaces and temporalities (Mayes, 2019). This leads us to understand the central voices in a situational and relational way. Namely, as rooted in the broader social and cultural context where they are found and in which they express themselves as individuals and find themselves linked to other agents. The latter, by projecting their views on the context, contribute to nourishing their ways of being and thinking, of attributing meanings to the world, as well as of behaving and acting in it (Letvak, 2003; Paliadelis & Cruickshank, 2008).

These other agents are the referential voices or what the framework of this article calls “peripheral voices” of a research project. Peripheral voices represent the group of usually privileged and at times secondary individuals, on which...
central voices spontaneously rely as a discursive and dialogical resource through which they understand themselves, the world around them and the position or status they occupy in it (Musaeus, 2017). The relationship between the central and peripheral voices can therefore be understood as a relationship of individual and social identity co-construction.

Ultimately, the identification of voices as central or peripheral in a study depends on the research question being answered. This explains why in some studies people or groups structurally relegated to the margins of dominant social or organizational systems become central voices, while those who hold privileged positions in such systems become peripheral sources of data.

Qualitative researchers deem the emergence of peripheral voices important, mainly during the stage of analysis of the data generated in the research. At this stage, the allusions that the central voices make to them contribute to illuminating the mechanisms through which they are mediated (limited or freed) by the discursive and social practices that prevail in the conditions that preserve it (Crowe, 2005; Fairclough, 1992; Foucault, 1971).

The inclusion of peripheral voices as participants in a study, when they have a privileged social status, may be seen a priori as contrary to the epistemological premises of qualitative researchers. We are supposed to give a voice to oppressed individuals and not to individuals who hold a privileged position in society. Theirs is an already socially amplified and recognized voice, so insisting on them could lead to the risk of perpetuating the silence of the central voices and of producing the status quo through research practices (Gergen, 2013; Stein & Mankowski, 2004). It is also assumed that the central voices are the most authentic in capturing the realities they live. It is not necessary for others to take the floor and issue their reflections on what they do not experience themselves (Fontana, 2004). Despite the aforementioned, we believe that working with central and peripheral voices as participants in the study contributes to guaranteeing the principles and ethical values of equity and justice on which qualitative research is based.

The inclusion of peripheral voices does not imply the displacement of the central voices from the privileged position that, temporarily, had been attributed to them in the study. The peripheral voices remain in the background of the established dialogue between the central voices and the researchers. Nor does this imply questioning the authenticity of the narratives of the central voices, since the purpose of their inclusion is not to verify or deny what the central voices express. It is to allow researchers to access a deeper understanding of the complex landscape of references to discourses, relationships and contexts present in the narratives of the central voices. It also grants researchers the ability to generate new knowledge that not only contributes to recognizing the processes of structural and social change leading to the emancipation of the central voices, but also to undo the mechanisms that generate conditions of oppression in society (Prilleltensky & Nelson, 1997).

Qualitative research designs, such as ethnographic studies, case studies or participatory action research, may use the collection and analysis of peripheral or secondary voice data to complement the data obtained from central voices. Nevertheless, there is currently no article proposing a methodological guide which explores both voices in a reflective and systematic way.

The objective of this article is to contribute to the field of qualitative research by providing a yet unpublished methodological and practical guide to identify, address, listen and analyze the narratives of the peripheral voices that emerge in what central voices report. This article builds on the insights we have garnered from conducting critical qualitative research on how nurses build and experience their professional status in healthcare organizations. This research is part of the doctoral thesis project of the first author of this article. The article is structured in the following four sections: we firstly state the stages in which the methodological guide consists. We then illustrate the details of the research, after which we develop each stage of the guide providing examples from our research. Finally, we discuss the strengths and weaknesses of the guide so that it can be used extensively in qualitative research.

Methodological Guide for the Incorporation of Peripheral Voices in Qualitative Research

The methodological guide presented consists of five stages as outlined in Figure 1. Figure 1 describes the objective of each of the stages, the questions that the analyzed text may be asked to guide the stages, and the expected result of each.

Presenting this guide as a successive set of five stages is only a didactic resource. It does not in any case imply that they must be carried out rigidly or linearly. In fact, throughout the research, the guide is applied in a circular and iterative manner, bearing in mind that researching with peripheral voices is emergent in nature.

Applied Research: The Construction of the Nurse’s Status in Healthcare Organizations

The data used to illustrate the practical application of the methodological guide come from an ethnomethodological research of discourse analysis aimed at understanding how nurses project the idea of social and political justice within public health organizations, and how they deploy their political agency to face the challenges and uncertainties of thinking about their institutional order when it fails to reflect their professional ethos. To explore this general objective, we were particularly interested in knowing how nurses construct their professional identity, what elements of (in)justice they
**Stage 1. Identification of peripheral voices in the narratives of central voices**

The objective of this stage is to identify the peripheral voices present in the textual corpus of the narratives of the central voices. The questions that may guide this stage are:

- a) What are the individuals, groups or structures to which the central voices refer?
- b) Do they have specific characteristics of a particular profile?
- c) What importance do central voices ascribe to peripheral voices in their narratives?
- d) What kind of relationship do you establish with them?
- e) At what time and around what themes emerge in the text?

The expected result is to obtain a generic list of peripheral voices associated with useful information to address stage 2 and to guide stages 3, 4 and 5.

**Stage 2. Design of the peripheral voices approach plan**

The objective of this stage is to design the plan to access peripheral voices. The questions that may guide this stage are:

- a) What inclusion and exclusion criteria should peripheral voices meet?
- b) How many peripheral voices should be involved in the study to respond to the objectives?
- c) What are the themes that should be explored in the encounters with peripheral voices and how should they be explored/asked?
- d) What strategies will be developed during the study to approach peripheral voices?
- e) How will recruitment be carried out?

The expected result is to have a complete plan to address peripheral voices for implementation in stage 3.

**Stage 3. Listening to peripheral voices**

The objective of this stage is the implementation of the approach plan developed in stage 2. The expected result consists in obtaining a textual corpus of the discourses and narratives of peripheral voices. This corpus may be obtained, for instance, from interviews or focus group transcripts, institutional documents or observation notes, depending on methodological decisions taken in phase 2. This corpus constitutes the analysis material of stages 4 and 5.

**Stage 4. Internal analysis of the narratives of peripheral voices**

The objective of this stage is the isolated analysis of the textual corpus of peripheral voices. The expected result is to obtain a coding tree together with illustrative verbatim that reliably reflect the narratives of the peripheral voices.

**Stage 5. Dialogical analysis of the narratives of central and peripheral voices**

The objective of this stage is to put the coding trees of the central and peripheral voices into dialogue. The questions that may guide researchers in this stage are:

- a) What are the points of convergence between your narratives?
- b) What are the points of divergence between your narratives?
- c) Are there silences (themes present in some narratives and absent in others)?
- d) What are the implications of the identified convergences, divergences and silences?
- e) What are the contextual factors that might offer an explanation for the results of the dialogical analysis?

The expected result is the acquiring of a new coding tree which incorporate the results generated by the central and peripheral voices.
identify in the organizations where they work, and what strategies they implement to make organizations fairer environments for them and, consequently, for the patients they attend. The theoretical framework on which the analysis of the data was based was the social justice theory of feminist philosopher Nancy Fraser. Ethical approval for this project was obtained by the Research Ethics Committee of the Balearic Islands (reference 4013/19 PI). All participants signed a written informed consent.

Nurses were the central voices of this research. Thirty-one practicing nurses in different posts and positions (care, middle management, management, political or collegiate positions, trade unions) in the public health organizations of the Balearic Islands (off the east coast of Spain) participated in semi-structured, in-depth, face-to-face interviews. Given the nature of the study, understanding the complexity of the results garnered from the interviews, required the identification, design of the approach plan, listening and analyzing the narratives of the peripheral voices identified in the nurses’ accounts.

The intention of this section of the article is not to present in detail the results of the research project. It is to show how the proposed approach unfolds on complex phenomena of study that arise from discourses, practices and power relations. In the case of our study, this phenomenon is evidenced within the construction of the status of a group of health care professionals (nurses) that have not been considered as equal within health organizations for historical and social reasons and have struggled to be fully recognized and respected within contemporary care environments.

Stage by stage: enriching the process of knowledge generation

We now describe each of the stages of the methodological guide while presenting examples from the aforementioned qualitative study.

Stage 1. Identification of peripheral voices in the narratives of central voices.

The objective of this stage is to identify the peripheral voices that emerge in the narratives of the central voices. Thus, the beginning of this stage requires the grounding of the corpus of analysis through the textual transcription of the data that the central voices have generated (Clark et al., 2017). It also requires us to take into consideration the notes on the context of the study and the data collection process appearing in the researchers’ field journal (Phillippi & Lauderdale, 2018). Once this preliminary step is performed, the researchers are able to point out the peripheral voices that emerge in the texts, and which the researcher will have to explore to enrich the research data.

Within the framework of our research, the analysis of the textual corpus of the nurses showed that, in their stories, they repeatedly referred to different individuals, groups or structures with whom they maintained a relationship. They also relied on said individuals to understand their own ways of being, doing and exercising their profession in health organizations and negotiating, building or challenging the organizational production of their nursing identity. The individuals and structures that constituted the peripheral voices of the research were physicians, organizational managers, patients and nursing assistants.

The nurses referred to them explicitly, but also implicitly when using personal pronouns (us, him/her, them). In the latter case it was necessary to clarify the participants whom they were referring to and, when we stopped having contact with the central voices, it was necessary to resort to a more revelatory work that attended to the broader context in which these pronouns appeared.

Subsequently, we analyzed each peripheral voice individually and collectively with all the peripheral voices interviewed to clear the framework (where and how) of their emergence in the text, discern if they presented characteristics that could correspond to a particular profile of participant, and distinguish the importance that nurses gave them in their narratives and the relationship established with them. Table 1 exemplifies this process. With the intention of keeping the design of the methodological guide as simple as possible we exemplify the next stages by focusing on the peripheral voice

| Peripheral voices | Descriptive notes |
|-------------------|-------------------|
| Physicians         |                   |
| • Physicians appeared in the nurses’ narratives regarding: |
| • The identity construction of nurses |
| • Understanding their general position within organizations |
| • The distributive aspects of their work (space, remuneration) |
| • Their professional recognition and the particularities of their interprofessional relationships |
| • Representing their voices in clinical decision-making |
| • The sociodemographic data highlighted by the central voices included gender, generation and medical specialty of the physicians. |
| • The importance of physicians was revealed in the constant and spontaneous use of the comparison with respect to this professional group |
| • The relationship they established with the physicians was characterized as being distant, aversive and hierarchical |
that most frequently appeared in the narratives of the central voices; the physicians. The Supplemental file 1: Stage 1 material provides some verbatim demonstrations of the data included in Table 1.

The results in Table 1 were useful in as much as they helped establish a generic list of peripheral voices allowing us to identify relevant information to elaborate the profile and the criteria for inclusion and exclusion of peripheral voices (Stage 2). This made it possible to guide the stages of data generation (Stage 3) and analysis of the narratives of peripheral voices (Stages 4 and 5). We will now discuss stage 2.

Stage 2. Design of the peripheral voices approach plan.
The objective of this stage is to develop the plan to address peripheral voices. This should include the criteria for inclusion and exclusion of peripheral voices, the projection of the initial number of peripheral voices to be included in the study (Robinson, 2014), understanding that it may be modified according to the saturation of the data (Fusch & Ness, 2015) and the outline of a list of topics to be explored.

In this research we considered the inclusion and exclusion criteria of physicians should resemble the criteria that had been developed for the central voices. We included physicians in active practice at the time of data collection and with a minimum work experience of 6 months, in order to simultaneously ensure the consolidation of the professional role and the non-restriction of the generations and medical specialties represented in the final sample of participants. These two broad inclusion criteria allowed us to respond to the descriptive notes previously detailed in Table 1.

The outline of themes to be explored was specific. Physicians were not to be recruited to talk about their personal realities and experiences, but to talk about nurses, the conditions surrounding the practice of the nursing profession and their relationship with them. Thus, among the topics to be explored with physicians were the construction of their identity as physicians, the identity construction they made of nurses, the distributive issues of resources, recognition and professional representation affecting nurses, and the role that the different health professionals who shared the space of health organizations played in maintaining the status of nurses. Table 2 shows the orientation of interviews with physicians. The themes to be explored ran from the most general to the most specific.

This particularity made the planning of the approach to peripheral voices a challenge for researchers. On the one hand, it was necessary to devise strategies to address the socio-professional dynamics at play during interviews. In this vein, before interviewing the peripheral voices, we had to carry out a work of reflexivity and positionality which had already been conducted prior to meeting the central voices (Bover, 2013). Being a young woman, a nurse and a researcher put the interviewer in a different position of power to that of the physicians. Her own preconceived ideas, her previous personal and professional experiences, her beliefs in relation to the object of study, her motivations and those perspectives and theoretical foundations related to her academic training and her political agenda, had to be worked before and through the data collection.

On the other hand, it was also necessary to devise strategies that would prevent physicians from interpreting the meeting with the researcher as a hostile and threatening environment in which they had to jostle, push and shove for a position of power. In this case, we implemented some strategies at different stages of the research process to minimize the possibility of this happening. These are described in stage 3.

Once the peripheral voices approach plan was completed, we were able to start the recruitment process. This process was performed using snowball sampling strategies. A total of 4 physicians were recruited to participate in the study. Their recruitment ended when the set of data generated allowed us to discuss the findings from the analysis of the nurses’ narratives in depth. Our purpose was not to reach saturation of the data generated by the physicians, though eventually their discourses were close to saturation. At this point in the guide, we

| Table 2. Provisional script of questions to physicians. |
|--------------------------------------------------------|
| Identity construction of physicians                    |
| - What is it for you to be a physician?                 |
| - What do you contribute in the interprofessional team and in relation to the patient? |
| Identity construction of nurses                         |
| - What is a nurse for you?                              |
| - What do you think nurses bring to the team and patient care? |
| - In what ways do you think they are important?         |
| Circumstances of professional practice of nurses        |
| - Do you think nurses can play their professional role as they would like? |
| - What problems do you think they encounter in their day to day? |
| - What is your opinion about the working conditions of nurses (workloads, availability of time and resources, salary, contractual conditions)? |
| - How would you describe your interprofessional relationships with nurses? |
| - How are decisions made in your team?                  |
| Role in maintaining or destabilizing the status of nurses|
| - Do you think changes are necessary in organizations?  |
| - What kind of changes?                                |
| - Do you think you have to play a role in them?         |
highlight that the inclusion of peripheral voices in the research may make it necessary to obtain additional ethical approval for the project before moving on to Stage 3.

Stage 3. Listening to peripheral voices.

This stage aims at the implementation of the approach plan elaborated in stage 2 and, subsequently, the encounter with the peripheral voices. We encourage researchers to carry out a pilot study at the beginning of this stage to identify possible gaps in the list of topics to be addressed. We also recommend they do this to evaluate the effectiveness of both reflexivity and positional strategies as well as specific strategies for addressing peripheral voices that have already been planned in the previous stage (van Teijlingen & Hundley, 2001).

The first contact with the physicians involved the deployment of the strategies for addressing peripheral voices devised in the previous stage. Thus, at the time of their recruitment, we explained in detail the objectives of the interviews. We explained that, through their opinions, the purpose of the interview was to understand their outlook and experience of the status of nurses within organizations. We informed them that we had interviewed many of the recruited nurses, that they alluded to physicians and other individuals in their narratives, and that this was why we showed interest in them. We also explained the role they were going to play within the research, despite not appearing in their objectives, and the importance of their voice to understand the narratives of nurses. However, we decided to start the meeting with the physicians utilizing rapport strategies (Prior, 2018). We first talked about issues outside the project, and then went on to review the objectives of the study emphasizing there were no correct or incorrect answers, just points of view on the same phenomenon. We also decided that we would then start the interview initially showing an explicit interest in them. The possibility of expressing the conceptualization of oneself before speaking of others could lead to two outcomes. It could both alleviate the sense of threat and facilitate the understanding of the position physicians held in the context of study, in relation to others, and subsequently the position and relationship they had with nurses.

The pilot study did not determine the need for modifications to any element of the approach plan. Nevertheless, it did allow us to observe a general tendency in physicians to turn the focus of interviews towards themselves. In this sense, we often observed that physicians positioned themselves in the interview as an element of comparison or reference. For example, when referring to nurses’ excess of workload, one of the participating physicians told us “Well, I don’t know about their workload, but what I can tell you is that here, physicians are overworked” and, another participant, referring to the availability of time that nurses had to carry out their work, told us “Time is limited for everyone, but especially for physicians”. This often forced us to redirect the interviewee to issues related to nurses and not them as physicians. This trend was itself treated as data. We also detected the need to redirect verbalized fears through expressions such as “I’m not sure I’ll know how to answer”, “I’ll try to answer questions I know about” or seeking nuance with utterances such as “this is my personal opinion, eh?”.

In this stage, field journal notes were especially relevant. They included references to physicians’ nonverbal behaviors as well as their interaction with the environment, and details about geographic location, environment, and the time at which interviews were conducted (during or outside of working hours). These details were significant in themselves and were used in the analysis stage to understand general organizational dynamics in the health system, together with the status of nurses in health organizations.

Interviews with physicians were transcribed verbatim to constitute the internal analysis material for stage 4 and the dialogic analysis for stage 5.

Stage 4. Internal analysis of the peripheral voices’ narratives.

This stage aims to isolate the analysis of the textual corpus of peripheral voices. This analysis is based on the premise that the narratives of peripheral voices are themselves important, being useful in understanding the complexity of a phenomenon shared with central voices. It unfolds a process of inductive and deductive data analysis (Azungah, 2018) that is mediated and influenced by the findings from the narratives of the central voices, and at the same time by all the data that emerged for the first time from the narratives of the peripheral voices.

In this vein, the internal analysis of the narratives of the participating physicians allowed us to understand how they built their identity independently, without alluding to, or relying on, other professionals for it. Accordingly, they managed to build themselves as legitimate professionals with authority over other professionals within health organizations (see supplemental file 2: Stage 4).

Nurses did not appear spontaneously in their narratives unless we asked specifically about them. The identity construction of nurses by physicians and the understanding they made of their importance in the teams were supported by interdependence with instrumental and utilitarian value. Here, “their” nurses were relegated to a secondary or complementary level to achieve a clinical objective they considered as their own, and therefore, not shared (see supplemental file 2: Stage 4).

Physicians shed light on those issues that placed nurses in a position of inequality within organizations. They explored issues that have to do with the availability of spaces, social recognition, interprofessional relations and decision-making processes (see supplemental file 2: Stage 4).

The view that the physicians projected on these issues was particular. They recognized certain circumstances as unfavorable to the nurses, they tended to take the discussion about it to their turf, arguing that they too should deal with such situations or blame the nurses. On very few occasions did they not answer what they were asked by saying “you’ll have to ask them about this” or “I wouldn’t know what to answer".
Despite this, they spoke on their behalf and almost always thought that they had the power to speak for the needs of nurses.

The physicians did not consider they had a role in restoring the nurses’ professional conditions. They avoided any kind of responsibility in the processes of change aimed at improvement, using arguments such as “their day to day is theirs, not mine” or that “this is your business”. These findings are supported by ample literature which demonstrates the power of physicians over allied health professionals and in the health system as a whole (Mattar E Silva et al., 2020; Reeves et al., 2008; Willis, 2020).

It should also be noted that the wealth of the data generated was strengthened by the fact that physicians spoke not only of their own opinions and experiences, but also of how they contrasted with the opinions and experiences of other physicians. In this way, their narratives gave way to new referenced voices that continued to promote the understanding of the object of study.

At the end of this stage, we created a coding tree together with descriptive verbatim that reliably reflected the narratives of these peripheral voices. The researchers then moved on to the fifth stage.

Stage 5. Dialogical analysis of the narratives of central and peripheral voices.

This stage consists of creating a dialogue from the coding trees of the central and peripheral voices, with the aim of analyzing how the narratives of one and the other are related so as to give a possible answer to the research question guiding the study. Specifically, it identifies the points of convergence, the points of divergence and the silences between the narratives of both voices to fully understand the central voices’ ways of being, thinking, building and acting in the world. This stage is therefore deeply marked by the principles underlying discourse analysis; a process of social research focused on the study of speech and texts, as a means of discovering the ways in which discourses construct and mediate the naturalized sociocultural and political reality of a given social and historical context (Fairclough, 1995).

The intention of this stage is therefore not to validate what the central voices express through what the peripheral voices say, since there are no correct or incorrect forms of experience, but rather, to understand the plural and diverse forms of experience that allow us to understand the same phenomenon from different perspectives. The intention is to bring together the different narratives to discover the power relations and forms of domination inserted into beliefs, behaviors, actions and social practices, as well as in the social and political order in which the central voices are immersed. This allows us to understand the mechanisms keeping this order intact and reproducing or challenging and subverting it (Crowe, 2005; Flick, 2014; Smith, 2007; Van Dijk, 2003).

Within the framework of the research project, the overlapping of the coding trees of the nurses and physicians involved made it possible to observe some points of convergence, divergence and silence in their narratives. Some descriptive excerpts from the results below can be found in the supplemental file: Stage 5.

Points of convergence were observed in the views that nurses and physicians had on the construction of a non-autonomous nursing identity (nurses always built it in relation to another and physicians built it as a complementary identity to their own). They also coincided on the particularities of their interprofessional relations (the recognition and criticism towards both territorial behaviors and medical dominance as well as the instrumental relationship that physicians established with nurses). Both groups also concurred on the blaming of nurses for their status in health organizations (the nurses blamed themselves and physicians blamed nurses).

Points of divergence were observed in the outlook that nurses and physicians had on the social recognition of nurses (nurses did not feel socially valued while physicians considered that the nursing figure was valued at a social level even to a greater degree than that of physicians). Additionally, they failed to agree on the ability of nurses to perform their professional roles free of limitations (nurses considered for the most part not to have the resources, recognition and professional voice to perform autonomously, while physicians considered that with some exceptions nurses could fulfill their professional roles). The views of both nurses and physicians also contrasted as regards the capacity of action of nurses to improve their professional conditions (nurses considered their professional group as static and somewhat immobilized, while physicians perceived the nursing collective as a fighting group and the nursing profession as a profession that had managed to evolve considerably in recent decades).

There were few silences in the results. This fact can be explained since as researchers we explicitly asked the physicians about those themes that had emerged in the nurses’ narratives (as described in the list of issues to be explored in Table 2). Even so, we identified silences in relation to the competence frameworks of nurses and the legal issues surrounding the exercise of the nursing profession (topics addressed by physicians, but not by nurses) and in relation to the treatment received by organizations or the lack of representation of nurses’ voices in decision-making at the macrostructural level (issues addressed by nurses, but not by physicians).

The implications of identifying the points of confluence, divergence and silence between the narratives of nurses and physicians were to aid the understanding of what social and political order dominated in health organizations. It also helped to detect the mechanisms by which this order was maintained and how the experiences of nurses were transformed by the experiences of physicians. Furthermore, it contributed to recognizing how asymmetries and power dynamics were generated between different narratives and identifying the emerging themes that would need further exploration in the future.
At the end of this stage, we were able to present the results acquired by the interconnected central and peripheral voices. We linked the results to the broader political, social, and cultural context that surrounded them and oriented them towards their future discussion through the use of theoretical frameworks guiding the research (Grant & Osanloo, 2014).

Discussion

In this article we have tried to contribute to the field of qualitative research by providing a five-stage methodological guide to help researchers identify, address, listen and analyze those peripheral voices that emerge in the narratives of central voices when researching complex social phenomena. There are several assets in incorporating and analyzing peripheral voices.

Cogitating the narratives of peripheral voices triggers the possibility of enriching the process of data analysis and, consequently, the knowledge generated through research. The participation of multiple voices integrating the ways of being and thinking as well as the central voices’ ways of understanding the context and acting in it allows us to comprehend holistically. This is done by focusing less on individuals or collectivities in isolation and more on individuals or collectivities as being closely linked to the broader social, structural and cultural context dialectically constructed (Mayes, 2019; Paliadelis & Cruickshank, 2008).

The inclusion of peripheral voices in the research is also consistent with criteria of methodological rigor (Morse, 2015). On the one hand, it allows the processes of generation, analysis and interpretation of data to partake in the inclusion of three agents (researchers, central voices and peripheral voices), each of which provides its unique perspective on the object of study. The peripheral voices and the voices of the researchers are therefore not elements of triangulation or validation understood as ways to compensate for distortions or to provide reliability or rigor to the central voices, but as resources that provide other means of appropriation or action towards the phenomenon. On the other hand, the transferability of research results may be improved by favoring an in-depth understanding of the complexity of the context in which they occur (Holloway & Biley, 2011; Polit & Beck, 2010) and the generation of local knowledge that can be more successful in implementing actions of change or improvement. Furthermore, the researchers’ own follow-up of the methodological guide elaborated in this article makes the process of data generation and analysis more transparent and reliable.

Following this guide does not make research rigid. The inclusion of peripheral voices in research gives it an open and emerging character that is progressively constructed and redefined as it progresses. Hence, the findings that emerge from the narratives of the central voices are the ones that guide the research process. Researchers need to align themselves with this dynamic process by developing openness skills that move away from rigid, restrictive, systematic and mechanical positions in research.

Similarly, although the examples chosen to illustrate the practical application of the guide have been extracted from a qualitative ethnomet hodological research project in which the interview has been used as a data generation technique, it can also be used with any other technique that allows the transcription of narratives such as discussion groups or documentary analysis. Moreover, through minor adaptations of the methodological guide presented, it would also be possible to apply it to ethnographic research that uses observation as a data collection technique.

Likewise, although this methodological guide has been developed as a guide useful to address peripheral voices understood as individuals’ narratives, it could also be used to address, interrogate, and analyze peripheral voices understood as larger structures or institutions, such as policy or regulatory documents that formally contribute to building and maintaining a certain institutional status quo. This may constitute a future line of improvement of the guide.

The examples chosen to demonstrate the application of the guide come from a research project that aimed to understand how nurses build their status as professionals within healthcare organizations. Nevertheless, this method can be implemented in any research project seeking to better understand, in a global way, the perspective that the central voices have on a certain study phenomenon that is considered as co-constructed or affected by power relations.

Finally, we emphasize that ethics in research is also promoted by the consideration of the peripheral voices present in the narratives of the central voices (Emanuel et al., 2000). This acknowledges both the inclusion (from a perspective of justice) of all those voices that in one way or another participate in a certain phenomenon of study and are affected by it. Moreover, it increases the social value of research through the generation of knowledge that seeks social transformation, not only through the emancipation of central voices, but also by destabilizing the status quo.

Conclusion

This article has contributed to the development of a five-stage methodological and practical guide for the inclusion of peripheral voices in qualitative research. The identification of the peripheral voices in the narratives of the central voices, the design of a plan for their approach, the listening to and the internal and dialogical analysis of both narratives, are of great value to researchers to aid full understanding of the complex study phenomena. The potential of considering peripheral voices as participants in the study responds specifically to questions related to the wealth of knowledge generated through research, methodological rigor in studies and ethics in research. We hope this research provides a useful tool for those researchers already familiar with the concept of peripheral voices by affording them a guide to follow in their research. Likewise, it may be used by those researchers not familiar with this concept by opening a new methodological perspective to explore and expand the knowledge garnered in their research.
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Supplemental Material
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