

# Why do we need qualitative research on psychological treatments? The case for discovery, reflexivity, critique, receptivity, and evocation

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**All research needs to be engaged, reflexive, and honest. We propose five functions that qualitative approaches may contribute to achieve these aims within the study of psychological treatments, write Per-Einar Binder and colleagues.**

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Historically, psychology has been dominated by positivist or post-positivist paradigms ([Guba & Lincoln, 2004](#); [Ponterotto, 2013](#)). Over the past decades, there has been significant growth in the use of qualitative approaches to psychotherapy outcome and process research. Qualitative methods are increasingly being recognised as useful for investigating the experiential world of clients and therapists. Their exploration of the relational context of clinical interventions and their study of personal growth processes has led to this recognition ([Elliott, Fischer, & Rennie, 1999](#); [Levitt, 2015](#); [McLeod, 2011](#); [Rennie, 2004](#)).

Moreover, the statements on evidence-based practice issued by Division 12 of the American Psychological Association and the Norwegian Psychological Association explicitly acknowledge the scientific status of empirical knowledge derived from qualitative research methods ([American Psychological Association, 2005](#); [Norsk Psykologforening, 2007](#); [Rønnestad, 2008](#)). This development parallels the broader recognition within the diverse field of psychosocial intervention research that well-performed qualitative studies are needed to enhance the clinical usefulness, conceptual robustness, and ecological validity of the knowledge base ([Castonguay, 2010](#); [Castonguay & Beutler, 2006](#); [Malterud, 2001](#)). Even so, randomised controlled trials still enjoy the status of being research's 'gold standard,' and the significance and contributions of qualitative research in the field of psychotherapy are seldom articulated explicitly.

We are a group of researchers located on the Western coast of Norway who have used qualitative approaches in our studies of psychotherapeutic processes, recovery, and user involvement. Through our own projects and as participants in the larger community of qualitative researchers, we have experience with using qualitative methodology in a broad range of ways. In what follows, we build on this experience to articulate five important functions of qualitative research in the study of psychological treatments.

Qualitative research can be defined as ways to describe, explore, and understand

the meanings of human interaction and experience through systematic collection of observations and explorative dialogue (Denzin & Lincoln, 1994; Kvale & Brinkmann, 2009). The basic facts of human interaction and, therefore, also psychotherapy are necessarily qualitative. Therapist and patient experience each other, and they feel, speak, and act based upon how they interpret and give meaning to these experiences. In traditional positivistic and empiristic approaches, qualitative observation is often regarded as necessary and as inductive ‘first steps’ before quantitative (‘real’) scientific observation can take place. Contrary to this consideration, the current wave of qualitative psychotherapy research is based on other epistemologies, where qualitative investigation is seen as an important supplementary source of knowledge about phenomena that, by their very nature, will never become fully quantifiable—such as processes of subjective experiences, relational meaning-making, and the sociocultural context always surrounding psychotherapy.

Qualitative methods are basically used to examine the ‘how’ and ‘what’ questions of process and change (Binder, Holgersen, & Moltu, 2012). Hence, they provide access to worlds of experience that help us contextualise findings from clinical trials and quantitative process studies addressing potential mechanisms of change. Through qualitative methodology, questions like ‘How did patients who benefited from treatment experience their change process?’ and ‘In what ways do the patients relate differently to difficult emotions or situations after participating in a given psychological treatment?’ can be explored. We argue that research on psychological treatments needs to address both statistical frequencies of specific process phenomena and outcome *as well as* subjective experiences and acts of meaning within the sociocultural and political contexts of psychotherapy. This position is also described as methodological pluralism (McLeod, 2011).

#### **Psychotherapy research is brought to life by its qualitative elements**

Qualitative research in the field of mental health predominantly utilises interviews with individuals or with groups of different stakeholders as the preferred data collection method. Another approach is participant observation in naturalistic settings. Observational studies have been influential within the broader field of mental health, demonstrating, for example, the powerlessness that people may feel in hospital wards (Rosenhan, 1973) or the potential negative effects of being hospitalised (Goffman, 1961).

We also maintain that psychotherapy research can never avoid qualitative elements. Although systematic use of qualitative methodology is a relatively recent development in psychotherapy research, qualitative observation and investigation have been part of psychotherapy since its very beginning. The development of psychotherapy theories has typically started with a case narrative. Sigmund Freud’s detailed case descriptions made psychoanalytic concepts and techniques comprehensible to other professionals—and to the general public as well. Joseph Breuer’s analysis of Anna O. marks the beginning of psychotherapy as a tradition, and it starts with a narrative of a particular relationship, therapeutic action, and

conscious and unconscious aspects of meaning ([Freud, Breuer, & Luckhurst, 2004](#)).

Freud's presentations of his case histories are what first made psychotherapy understandable as a form of practice and human interaction. His case stories were also a way to both build and illustrate theory. His approach was an attempt to persuade the reader to believe in the theory of psychoanalysis by translating metaphysical and rather high-level theoretical constructs into the context of individuals' lives.

Through its qualitative nature, the case story can illustrate what an 'interpretation' really is and how patients may react to it. Freud's observations in formulating his case narratives also allow the reader to discuss Freud's claims. For instance, we are not necessarily convinced that Dora's reaction to Freud's interpretations of her hidden erotic feelings for Mr. K. is to be understood as resistance to insight ([Freud & Rieff, 1963](#)). It is not only psychoanalysis that is made understandable through qualitative observations. Is it, for example, possible to fully conceive what an automatic thought in cognitive therapy is without narratives given as illustrations of this particular concept? And how are we able to understand the role of chairwork and empathic reflection in experiential therapies without specific descriptions of intentions and interactions? In the same way that a good novel may address important aspects of the human condition, clinical narratives about a particular individual and a particular therapy dyad can potentially shed light on aspects of both cultural and existential domains in psychotherapy.

#### **Vitality needs to be balanced by reflexivity**

Case narratives are not enough to establish an empirically sound and comprehensive knowledge base in the field of psychotherapy research. The traditional case story also suffers from significant epistemological and methodological limitations. Lack of generalisability is often pointed out as a central issue. The often-cited poem by William Blake that depicts seeing 'the world in a grain of sand' is a beautiful metaphor, but it requires careful translation to work within a scientific context. Blake shows this necessity in his exaggerated verses nine and ten from the same poem: 'A dog starved at his master's gate, predicts the ruin of the state.' Binder, Holgersen, and Nielsen ([2009](#)) studied a sample of 10 former patients who attributed their positive outcome from therapy to, among other things, having had a relationship with a 'warm and wise' professional. The authors pointed out that this, of course, does not mean that being a warm and wise therapist predicts positive outcomes for all patients in all contexts. Because generalising a finding from an individual or group to larger segments of the population is not the main task of qualitative approaches, researchers within this tradition are rather humble and attentive, and they try not to make general claims, sometimes maybe even trying too much not to. Indeed, sometimes a starving dog might signal bigger problems, as addressed later in this paper, in particular in the section on critical function. The issue at hand is rather the sober reflexivity over when that might and might not be the case.

A problem that often goes unnoticed in qualitative research is that the epistemological reflexivity on the part of the observer and narrator is often insufficiently addressed. Those who read Freud will be struck by his eagerness to convince us that he is right. For example, he believes resistance is something that lies within his patients and not something that he actively contributes to as a therapist. One can also sense a certain plot coming from many of his cases, along the lines of 'I will demonstrate how people are much more complex and destructive than they think they are.' In the same way, one can come across case narratives from rationalist versions of cognitive behavioural therapy, where the agenda becomes 'if you think life's problems are complicated you are infected by unscientific attitudes and fuzzy logic; now I am going to tell you how simple and easy it really is.'

A systematic qualitative inquiry with a higher level of self-reflexivity about one's role as a participant observer and also upon one's basic assumptions and preconceptions would certainly enrich the field. Becoming more reflectively aware of typical rhetorical tools in one's preferred mode of psychotherapy and of typical plots and storylines dominating particular narratives also provides more opportunities for a constructive internal critique and for the further development of a given psychotherapy model.

In empirical science based on quantitative principles, the influence of the researcher is secured through rules and conventions on how to handle the data. These rules also have to be shared; the community of researchers must (more or less) both agree upon them and systematically try to improve them. In qualitative research, too, we can make use of procedures that, to a certain degree, help us ensure that our findings will not be overly influenced by our preconceptions. One way researcher teams can accomplish this aim is to systematically use critical self-reflection about one's preconceptions and possible investment in particular outcomes throughout the research process ([Binder et al., 2012](#); [Hill et al., 2005](#)). A team of researchers can work in line with certain agreed-upon ways to structure their discussion and have rules for how to arrive at a consensus about major themes in the data material. However, as will be discussed later, focusing on consensus may also run the risk of eliciting mainly conventional understandings ([McLeod, 2011](#)). An auditor, external to the researcher team and with less investment in certain outcomes, can be quite useful in discovering potential confirmative biases in handling the data.

Observer bias can become a major problem when we interpret qualitative material. In attempting to handle texts or observations with ambiguous meaning, we often see what we expect to see and maybe (subconsciously) want to see. Some proponents of qualitative research tend to write this tendency off as a typical positivistic prejudice, but we recognise it as an important epistemological and ethical challenge in qualitative therapy research. For example, when we analyse interview transcripts, some interpretations more closely reflect what participants really experienced than others. On an ontological level, we presuppose that the participants do have an experiential horizon of their own, independent from ours.

And in line with dialogical hermeneutics, we think that is a necessary presupposition ([Gadamer, 1989](#)).

The basic premise underneath the more specific functions of qualitative research is to balance proximity to the experiential world of research subjects, with an ongoing consideration of one's participation as a researcher. This balance should be done in a way that is transparent to the reader of the research, and it will be the focus of discussion in the remainder of this paper. We will use some examples from our own research to articulate, explore, and discuss five important functions of qualitative research in the study of psychological treatments.

#### The discovery function

Although we are critical about the classical idea of limiting qualitative inquiry to the first step of discovery of a given phenomenon, we agree that discovery lies at the heart of qualitative research. As in all methodologically sound research, a basic question is: Does this observer become surprised by something he or she sees or hears? All research is based on the principle that one allows oneself as a researcher to admit ignorance about a certain subject or phenomenon. Research is an activity that aims to fill in these gaps in knowledge. Delayed help-seeking among trauma survivors is, for example, well established within the field of psychological trauma ([Wang et al., 2005](#)). How to understand this delay and the mechanisms behind it, however, is not well understood. Interviewing 13 trauma survivors about the process that led them to seek help following childhood trauma provided examples of what mechanisms contributed to delays in help-seeking for these participants—including the interplay between a coping strategy of self-management and situational demands ([Stige, Træen, & Rosenvinge, 2013](#)).

One example of how qualitative data can be interpreted separately from confirmative bias can be drawn from our knowledge of mental illnesses. According to Davidson ([2003](#); [2013](#)), people's experiences when struggling with schizophrenia have occasionally been subordinated to traditional conceptions of what those experiences should be like. Persons struggling with negative symptoms, for example, have at times been seen as reclusive to the point of being asocial, that is not missing or desiring human contact. Qualitative studies, however, have demonstrated how people with predominantly negative symptoms consistently express being lonely and desiring love and friendship ([Davidson et al., 2001](#)). Similarly, in a qualitative study we conducted on the lived experiences of young adults who were seeking professional help for social anxiety ([Hjeltnes, Moltu, Schanche, & Binder, 2015](#)), the participants described themselves as having actively attempted to hide their own experiences of insecurity and vulnerability by 'acting' or 'hiding behind a mask' in their interactions and relationships with other people. By interviewing trauma clients twice, upon completion of group treatment and again one year later, we discovered a marked change in the way participants related to the skills they had learned in therapy. From being something external, that is a tool they could apply, the skills became integrated and part of the participants' way of being in the world ([Stige & Binder, 2016](#)).

When qualitative inquiry fulfils the promise of discovery, it can support further quantitative inquiry. If you first interview patients about what helps and hinders the process of change in the context of struggling with a mental illness or in seeking help following childhood trauma, then you can develop quantitative questionnaires that assess both facilitating and hindering factors. Such a solid qualitative base for self-report questionnaires can contribute to new kinds of discoveries about the frequencies of these factors and the possible covariance between them.

#### The reflexive function

The full potential for qualitative research as an independently contributing force is reached when aiming for something more substantial than correcting biases. There are also moments of surprise and wonder that occur when participant accounts make us aware of our implicit assumptions. This can be assumptions about what it means to be a patient, what the therapist role might consist of, what it means to heal or to recover, and what collaboration in psychotherapy is and might be. These are the moments when our 'dialogue' with the data helps us have a richer reflexivity. Following are some examples from projects by our research group.

When interviewing people with bipolar disorder who had experienced a beneficial change in their life as a whole, it became clear to us how simplistic and conventional our preconceptions about recovery were (Veseth, Binder, Borg, & Davidson, 2011). Even without consciously adhering to simplistic views, we became aware that with patients from this particular diagnostic group, we were more focused on recovery solely based on symptom reduction than we were with other patient groups. In other words, by conducting this study, we recognised that recovery is a much broader and complex phenomenon, encompassing more of relational and everyday life than our original preconceptions warranted.

When interviewing patients about good outcomes and change in psychotherapy in a study by Binder, Holgersen, and Nielsen (2010), it became more real to us how the words or constructs of recovery meant quite different things to different people. And when we analysed the interviews of participants whose reduction in symptomatic distress played a significant role in their life as a whole, it became clearer how relationally and experientially oriented our thinking sometimes was compared to the participants.

In another study (Binder, Moltu, Hummelsund, Sagen, & Holgersen, 2011), it was striking to the interviewer how different it was for a professor or a researcher to relate to teenagers compared to relating to them in the role of therapist. This distinction clarified some aspects of both roles: The adolescents had a more elaborate description of their emotional interaction with their therapist than the interviewer had expected from them based on his experiences as a therapist. They seemed more comfortable and open when relating to him as a researcher than as a therapist. This prompted several lines of reflection. For example: Does this finding only have to do with the interviewer as a therapist versus a researcher? Or could it be that some aspects of the therapist role can affect adolescents' self-disclosure in a limiting way?

In the mentioned qualitative study of what kind of life experiences lead young adults to seek help for social anxiety (Hjeltnes et al., 2015), we found that the informants themselves actually described their own sense of loneliness and their fear of isolation in the future as the most distressing parts of their experience in everyday life. This stands in contrast to the expectation that participants would primarily describe experiences adhering to the specific symptoms and impairments listed in the psychiatric descriptions of social anxiety disorder.

In a final study, this one based on interview data from therapists working on therapeutic impasses that ended constructively (Moltu & Binder, 2011; Moltu, Binder, & Nielsen, 2010), we were struck by how embodied and fragmented the experiences of therapeutic impasse were for the participants. We had assumed that they would primarily rely on their cognitive faculties in their work with impasses; that is, they would tell us about their thinking, insights, conceptualising, and so forth. They did not. Rather, they talked about aches and stomach pains and about their confusion in being caught in a serious therapeutic stalemate.

Constructing a common platform between the experiential horizons of participants and one's own also makes our landscape of implicit assumptions, preconceptions, and prejudices more visible (Gadamer, 1989). Self-reflexivity is something one can arrive at only in solitude. On the contrary, self-reflexivity arises and evolves in dialogue and through 'meaning making' when interacting with persons whose experiences and assumptions about the world are different. Hence, reflexivity is part of both the research process and the assessment of findings from each particular qualitative study in which one is engaged (Alvesson & Sköldberg, 2000; Finlay, 2003). As shown in the examples above, reflexivity can be situated on different levels:

1. Self-reflection and reflexivity concern one's implicit assumptions, such as one's ideas about how to behave in the role of a therapist.
2. Reflexivity concerns implicit theoretical assumptions, such as one's ideas of what it implies to be a patient, what role(s) symptom relief may have, and other areas of importance in patients' lives beyond the attainment of symptom relief.
3. Reflexivity concerns the political and ideological landscape of psychotherapy, such as how much it, implicitly, may medicalise our understanding of problems in living or whether it takes new forms as a type of commodity on a market where patients become 'customers.'

Reflexivity and interpretation are two closely related phenomena in qualitative research. When one is trying to interpret subjective experiences and events in psychotherapy, a 'fusion' of horizons occurs between the therapist and patient (Gadamer, 1989). A true meeting with the experience of others makes personal prejudices more visible. At the same time, having an experiential horizon anchored in a system of meaning making is also what renders dialogue with others and new understanding possible. Imagine, for example, a hungry extraterrestrial creature accidentally lands on our planet and then steps into a dinner party, knowing

absolutely nothing about life on earth. How would such a creature know how to seat himself on a chair, rather than on the table or on the floor? How could it drink from the glass rather than from the hot sauce bottle? How could it interpret things that happen, such as certain people serve food while others sit passively, expecting to be served? Are they kings and slaves? Foreknowledge is necessary for any accurate understanding to occur at all. Having expectations based on preconception is what lets us see breaches of the ordinary and occurrences that yield interesting potential. The hermeneutic circle of understanding is the ongoing relationship between the subject and the world, when what is already known is challenged by what is different, new, or unfitting (cf. the dynamic interaction between experiential assimilation and accommodation).

When we interpret utterances from participants and construct themes or categories, we ideally transform our preconceptions into something new in the meeting with the otherness of the person's voice and perspective. We use our background as a resonance to bring voice to the participant's experiences or ways of making meaning from events, ideas, or types of interaction in psychotherapy. Then, our ideas of what it is to be a therapist or patient, what matters in therapy, and what types of interaction occur are transformed, and new understanding takes shape and becomes articulated.

One basic function of research is to raise new questions. Reflexivity is about raising fundamental questions, types of questions that cannot solely be answered by numbers (Finlay, 2003). Therefore qualitative inquiry is necessary for psychotherapy research to stay vital and well-connected with the phenomena we study.

#### The critical function

The reflexive and interpretive functions of qualitative research are closely linked to their critical potential (Alvesson & Sköldbberg, 2000). Becoming more aware of one's implicit preconceptions and prejudices can open up possibilities for critical inquiry: Is there an implicit medical paradigm in our ideas about improvement and treatment response? Do certain forms of psychotherapy and the use of therapy in general foster conformity to malfunctioning or unhealthy social conditions (Cushman, 1995)? Is there an implicit patronising power structure in the constructs of adherence? Are there bourgeois or conformist perspectives on deviance and normality that need consideration? How does therapeutic discourse handle questions regarding sexual orientation and gender? What role does therapy play in a consumer society where persons as well as particular therapy models require 'advertisement campaigns' to secure their existence?

Forms of qualitative research that address human interaction, relationships, and power structures are especially well-suited for this kind of exploration, for instance, in discourse analysis and conversation analysis (McLeod, 2011). However, also more hermeneutic-phenomenological, thematic, or grounded theory forms of analysis will give rise to such types of critical inquiry (Rennie, 2012). Moreover, in the design and focus of qualitative research itself, groups that are traditionally

marginalised can be given a voice. For example, by exploring other-initiated versus self-initiated help-seeking among 13 trauma survivors, it became clear that a praxis of judging motivation and denying health services solely based on the number of previous consultation series ran a high risk of excluding motivated survivors in need of mental health services (Stige et al., 2013). Pugach and Goodman (2015) studied low-income women's experiences in out-patient therapy and showed how we need nuances of understanding to differentiate no-show and attrition that point to low motivation or lack of structure among this population. The study determined that providers of out-patient therapy in that particular context were experienced as non-adaptive by women carrying the load of multiple low-wage jobs and single parenthood because of unwelcoming business hours and inflexible rescheduling practices.

Patients' and service users' ambivalence about how mental health services are offered is possible to explore when we get closer to personal experiences. In a study of adolescents' experiences with assessment and diagnosis, we discovered there were both participants who found relief when a diagnosis was offered because symptoms then became less frightening and others who found their fear of stigmatisation confirmed (Binder, Moltu, Sagen, Hummelsund, & Holgersen, 2013):

*Participant: I don't like the topic of 'diagnosis.'*

*Interviewer: Let me hear?*

*Participant: I don't know. Most of all it has to do with time. I don't think that three sessions is enough. He doesn't know enough then, because I have not opened up enough yet. I do know that I have opened up at a superficial level, and told some specific stories, but I've not gone into the depths of anything. And I feel that it is a little bit weird to set a diagnosis. I don't know if it's right to put a diagnosis on everything. Does it have to be an illness, when I've had a couple of bad experiences? Does it mean that I have developed some kind of mental illness? Perhaps the only important thing is to talk about what has happened ... (p. 112–113).*

Moreover, Viklund, Holmquist, and Nelson (2010) studied processes of disagreement on the micro level, defined through conversational analysis as important events by clients. Through micro-analysis the researchers found and discussed both constructive and destructive ways of handling disagreement in the therapeutic dialogue in interesting clinical detail. They also managed to demonstrate power imbalance in the therapeutic relationship, even when the balance is a constructive one. This is an important empirical clarification of a therapeutic aspect that is often mentioned but rarely translated to a concrete clinical level. The strength of qualitative methodology lies in its ability to address meaning patterns and structures on different levels and, therefore, to move beyond

the traditional questions in psychotherapy research such as 'What forms of therapy work for whom?' Qualitative inquiry can explore more social and cultural contexts of psychotherapy. It can also study how treatment is influenced.

#### The emotional receptive function

In qualitative inquiry, the emotional side of the research process comes more to the fore than it does in quantitative research. This does not mean that quantitative researchers are less emotionally invested. However, qualitative material is dependent upon interpretation and is more sensitive than numbers to the researcher's emotional approach. In terms of observer bias, this is certainly a limitation. But using one's emotional receptivity also opens up epistemological opportunities.

Interviews still seem to be the main avenue for data collection in qualitative studies. When it comes to interviews, the role of emotional receptivity is quite obvious. The interviewer's empathic attitude deepens the interviewee's experience and thereby the material gathered for further investigation as well (Rogers, 1945). Empathic introspection and contact in the interview is dependent upon the interviewer's emotional resonance and engagement in the interview relationship. When interviewing therapists about therapeutic impasses (and thereby implicitly their feelings of frustration and being stuck) the interviewer's capacity to take part and be engaged in the emotional atmosphere of these narratives is a significant part of the material (Moltu & Binder, 2014). This tendency is very much in line with relational psychoanalytic views on countertransference as a possible source for deeper knowledge and understanding of the patient's affective state (Aron, 1996; Gelso & Hayes, 2007).

Emotional receptivity is not only at work during interviews and in vivo interaction with the participants. It is also important when it comes to deepening the understanding of interview material in the form of written text or audio or video material of therapeutic interaction. When we interpret human experience, interaction, or meaning making, we always try to pick up a felt sense of 'what is going on here.' Emotion plays a fundamental role in human experience and interaction, and picking up this felt sense is part of coming to a full understanding of the phenomena under study.

After perceiving, experiencing, and resonating with the material's emotional messages, more systematic analytic work must take place. Especially because emotions are sometimes quite idiosyncratic and dependent upon the researcher's background, serious misunderstandings can result. This propensity is in line with the classical understanding of countertransference as a product of the therapist's blind spots. Searching for and formulating themes and meaning patterns in a systematic way (e.g., through line-by-line coding and comparisons of different parts of the material) stimulates an analytic and reflexive look at the material, something which may help to counteract too much noise in one's emotional perceptivity. However, team-based approaches to analysis should be considered as the preferable way to overcome idiosyncratic emotional perceptions. An emotional tone

in the material can then be felt and picked up by more than one researcher, who can discuss it and secure both immediate emotional receptivity and cognitive and verbal processing.

Through systematic use of emotional receptivity, qualitative research can help us come closer to the sadness, frustrations, disappointments, hope, and joy that comprise central phenomena in psychotherapy. In a study of what therapists need, during therapeutic impasses, to be able to work constructively (Moltu & Binder, 2011), one of the themes presented was the therapist's necessity for 'a witness' to the stalemate situation. In this study, we could open up and get closer to the experiential texture of countertransference management than we could, for example, from knowledge established through a survey. One of the quotes illustrating this theme was: 'I need someone to meet me . . . to get a little . . . clarity around my reactions. The feeling of not being . . . What it does to you when you're banging against something. It feels good to talk aloud about that feeling . . . getting to what that feeling gets going inside of us. We all got our own stuff. We too, we got ours, right?' (p. 260). In carrying out this research interview, it is not a simple matter of a researcher receiving information. Rather, it is a matter of being invited into the emotional reality of the participant and being receptive to that reality.

Moreover, in the process of bringing emotional qualities from the field of practice to scientific presentation, both researcher and participant can experience changes through emotional receptivity. To illustrate this theme in 'The move: From confusion and bodily tension to shared systems of meaning' (Moltu & Binder, 2011), we presented the following quote in which the participant refers back to the first of two interviews with the researcher:

*... when she feels like she is blown to pieces from the inside out of anxiety . . . sitting close is like holding on to something for her [ . . . ]. And I have been thinking, many times, that I would have liked to offer her my hand then, sort of holding on to her. I can do that. But with her it is strange. My hands have always felt so cold when I talk with her, so I have felt I couldn't offer [anything]. I had nothing to offer because my hands would be as cold as hers. But after I had talked about it, in the first session back in therapy, she was anxious and dissociated, and then I felt so warm. My hands were really warm, and I offered: "How would you feel about holding my hand?"*  
(p. 258)

The detailed nuances of experiences with the intrapersonal and interpersonal tensions that go along with difficult processes in therapy benefit the research reader by lifting the experience to the fore, rather than merely effecting cognitive comprehension. This receptive process can sensitise readers and researchers to the emotional complexity of these situations. When combined with the use of systematic tools and checking in with other researchers' perceptions and understanding of the material under study, opportunities for 'getting close' to the

material in ways that are difficult for both a single clinician in his or her daily work and also for the researcher who relies on quantitative measures only are opened up.

#### The emotional evocative and aesthetic function

When conducting an analysis, the researcher's aim is to extract meaning from the particular words and interactions that are spoken or occur in interviews or therapy sessions to arrive at a more general level of abstraction. Researchers may find it challenging to present the emotional meaning of experiences or emotions felt in therapeutic interactions in ways that bring them to life. How can they be analysed and formulated as themes or categories that are systematic, reliable, and at the same time emotionally vital? In scientific discourse, we tend to associate 'truth' and 'trustworthiness' with 'correspondence with reality.' Of course, this is an important criterion for defining truth in qualitative research as well. There is a continuum between realist positions, where language is more or less assumed to mirror reality, and interpretive positions, where language is assumed, to a larger degree, to form and shape what we experience as reality. Truth always involves what is real. But in presenting or communicating emotional meaning in a truthful way, something more is needed. For example, how can we explain the sense of disappointment or joy without evoking the feeling of witnessing disappointment or joy? When searching for a more basic sense of truth, Heidegger (1996) turned to the old Greek concept of 'aletheia': to let that which is hidden become disclosed and to let a phenomenon appear and stand out as it is. To be truthful to emotional realities, one has to communicate emotions so that their meaning resonates. As an example, Finlay and Evans (2009) argued that the trustworthiness of qualitative research depends, to some degree, upon this very resonance. Hence, when evaluating a study, we need to ask ourselves: Will a particular reader be able to capture the emotional feeling of our descriptions? Are the presentations of the findings vivid or powerful enough to touch the audience on an emotional level and thus create empathic resonance?

In qualitative research, analysis and writing are more closely connected than in quantitative research (van Manen, 2014). In quantitative analysis we 'translate' empirical material (presented as variables) into numbers. We then conduct statistical calculations and analyses on these numbers and finally describe and communicate the results in a statistical language. The interpretation and discussion of results really call for verbal reflection. In contrast, language is a main analysis tool in qualitative research. The qualitative analysis is conducted on verbal texts or verbal accounts of observation, and the formulation of a meaning pattern from the given material, a theme, or a category is an activity that is wholly dependent upon verbal language.

When we present findings related to human experience and interactions and try to stay close to these human and relational realities, the conscious use of evocative and aesthetic functions of language are crucial. Use of metaphors and presentation of 'proto-narratives' or experientially rich excerpts from interviews are examples of this. One has to be careful – it is not without reason that scientists are often

sceptical when it comes to focusing on aesthetics – since language use can also easily become seductive and distort realities. In identifying main trends in any given material, conscious and reflective use of aesthetic and evocative linguistic tools must be combined with transparency, and a critical look at the limitations of the actual study is always required. A qualitative study functions at its best when human realities are presented in a form that brings them to life and when the presentation is combined with a tentative, explorative, and critical attitude toward one's findings. This is nicely illustrated by Finlay and Payman (2013), who built on Todres' (2007) differentiation between texture and structure in the data material and highlighted the importance of balancing an emotional, evocative closeness with a rigorous scientific distance.

#### Qualitative methods and their place within psychotherapy research

Quantitative methods have provided critical knowledge and scientific advances in the field of psychotherapy. A number of studies have, for example, demonstrated the importance of patient feedback and the risks of deterioration in psychotherapy (Lambert, 2010). Some of this research addresses aspects of the therapy process that are not easily recognised at an experiential level, at least not among clinicians themselves. Hence, important correctives to what we think we know are revealed. But as we have argued in this article, there is also more to psychotherapy than can be learned through quantification and measurement alone. Knowing *that* feedback can improve the quality of difficult therapeutic processes needs to be followed by knowledge about *how* feedback can do this and *what* patients and clinicians experience as the most important processes with regard to working with feedback. For example, Sundet (2014) studied how clients experience clinical feedback tools and could detail four important conversational processes that occurred. Moreover, Moltu et al. (2016) studied the need for clinical feedback systems to support and address the important challenges in therapy processes that patients and therapists experienced. In sum, qualitative research, as exemplified in this particular context, can expand on quantitative knowledge and provide the field with something more. It accomplishes this goal by offering important clinical insight into *how* and *why* the quantitatively based knowledge works.

We have aimed to capture the nature of this 'something more' through the five potential functions of discovery, reflexivity, critique, emotional receptivity, evocation, and aesthetics. On the one hand, qualitative inquiry holds the potential to bring us closer to the heart and soul of psychotherapy—to the experiences of patients and therapists and their specific types of interactions (i.e., hope, joy, fear, sadness, and frustration) found within the therapeutic relationship. After all, the core of psychotherapy is nothing more and nothing less than these human interactions between patient and therapist. On the other hand, qualitative inquiry also has the potential to give us a distance that broadens our perspective and helps us see psychotherapy in a sociocultural, historical, and political perspective.

But what are the limitations of qualitative inquiry compared to quantitative approaches? As pointed out in the introduction, we both hope and think that the 'for

or against' phase in the relationship between the two methodological approaches will soon come to an end. A premise for this possibility to become real is to admit that each approach has both advantages and limitations which can positively contribute to each other as methods of discovery. Depending on the content of specific hypotheses, there are areas of exploration where quantitative approaches are the most relevant for answering certain questions. For example, to assess outcome or the effect or efficiency of a given form of treatment presupposes a quantitative approach. That is because it is connected to the question of 'how many participants improved' or 'how much improvement was observed in a group or an individual.' Also, changes in such quantitative measures within a time line can help us answer questions about causal relationships. Qualitative and quantitative methodologies have distinctive strengths and weaknesses, and the rationale for using mixed methods is to combine these different strengths and minimise the weaknesses of quantitative and qualitative approaches ([Johnson, Onwuegbuzie, & Turner, 2007](#); [Morgan, 2013](#)).

Psychology and psychotherapy research has historically been dominated by positivist or post-positivist paradigms that emphasise quantitative approaches ([Guba & Lincoln, 2004](#); [Ponterotto, 2013](#)). However, the functions that we claim are important for qualitative inquiry to fulfil are formulated from the point of view that qualitative methods of inquiry can supplement quantitative approaches and that they can answer questions that cannot fully be answered through quantitative explorations. Using both sets of methodology can provide a richer research process and a more comprehensive base of empirical knowledge by illuminating a broad range of research questions. Quantitative approaches can illuminate to what extent a certain therapeutic strategy or technique brings about a good or a bad outcome for a number of patients receiving that type of treatment. Qualitative approaches can tell us *how* patients experience their treatment process, whether their outcome is good or bad. In this way, a qualitative approach not only can fill in the gap regarding what numbers can tell us but can also give rise to a constructive critique of what is measured in quantitative studies. For example: Was the 'good outcome' experienced as a meaningful and relevant outcome? Was it worth the effort of going to therapy? Did the patient's experience of a 'bad outcome' have to do with the particular form of therapy or to the relationship with the therapist, or was it something about himself or herself and his or her life that affected the change? Or did the patient experience types of outcome that the quantitative measures did not address in 'bad outcome' cases? In a recent mixed methods study of mindfulness-based stress reduction (MBSR) on young adults with social anxiety disorder ([Hjeltnes, Moltu, Schanche, Jansen, & Binder, 2016](#)), we first used quantitative measures to identify those participants with the most and least change in their symptoms. Subsequently, we analysed qualitative interviews with these groups of participants to investigate *how* they experienced the MBSR programme. The aim of this 'mixing' of quantitative and qualitative analysis was to investigate 'both sides of the story'—by giving a voice to what the improved and less-improved participants experienced as the helpful or challenging parts of the intervention. There may be a sound rationale for mixing methods when qualitative approaches can offer critical views on quantitative findings, and vice versa. However, it is important to recognise

that 'mixed methods' approaches are not without complications.

Although these types of methodology may address the same phenomena, they explore different types of questions (Johnson & Onwuegbuzie, 2004). A complex question of 'why did change occur or not occur' in quantitative research takes many factors into consideration and may require a lot of space for both methodological and substantial discussion of its premises. Then there might not be sufficient space for a qualitative 'how' question, or it may not be considered relevant for the particular topic being discussed. The situation may be the same when it comes to entering deeply into a questions of 'how was this experienced' and 'how did they interact.' A discussion of meaning may leave out irrelevant questions about quantifiable variables and their covariance, at least for a while.

There are also voices within qualitative research that are sceptical toward a mixed methods approach for more fundamental reasons. From a more radical constructivist perspective, one may say that the epistemologies behind qualitative and quantitative approaches are so diverse that the different types of data they provide are not comparable. Our epistemology is closer to a realist position in the sense that we regard numbers and verbal language as ways to describe different aspects of the same reality. However, this reality is only possible to reach through interpretations. Being open to a multitude of perspectives on 'the same' world, therefore, also becomes a goal in itself. Consonant with Denzin's metaphor, we see the psychotherapy researcher as a pragmatic 'bricoleur' (Denzin & Lincoln, 1994), applying whatever useful material is at hand to illuminate both the psychotherapy process and outcome. This viewpoint also puts us on a more pragmatic side than the 'purist' approaches within the qualitative methodology field. Not so different from a therapist's preference for one particular school of psychotherapy, there are advocates of certain methodological approaches who would say that strictly adhering to one approach secures the best result. Our basic assumption is that methodological purity has not shown the best results, neither within psychotherapy as a practice nor when it comes to studying it. Innovative and critical understanding thrives and grows when perspectives and horizons meet.

#### Conclusion

Research on psychological treatments needs to be diverse. A broad variety in the topics we study, as well as in our methodological approaches, is required to capture the complexity and heterogeneity of change processes within and between individuals. Moreover, research on psychological treatments needs to be vitally alive. The forms of knowledge aimed at helping us understand and explain the important and vital interpersonal relationships that constitute the practice of psychotherapy need to mirror the intensity and emotional complexity of this very practice. Ultimately, all research needs to be engaged, reflexive, and honest. In this paper, we have described and discussed five possible functions that qualitative approaches may contribute to achieve these aims within the study of psychological treatments. These include (a) a discovery function, (b) a reflexive function, (c) a critical function, (d) an emotional receptive function, and (e) an evocative and

aesthetic function.

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#### Abstract

Psychotherapy researchers are increasingly using qualitative approaches to gain knowledge about the experiential, relational, and sociocultural aspects of psychological treatments. In this article, we explore and discuss five core functions of qualitative approaches within this field. They include: (a) a discovery function—to fill in knowledge gaps and challenge our pre-assumptions; (b) a reflexive function—to make ourselves more conscious about our prejudices and basic assumptions on personal, theoretical, and ideological levels; (c) a critical function—to address contextual issues of political and social injustice; (d) an emotional receptive function—to offer an emphatic listening perspective that facilitates the exploration of the emotional realities of psychotherapy; and (e) an evocative and aesthetic function—to communicate the experiential realities of psychological treatments that bring these realities to life while also providing a deeper understanding.

**Keywords:** psychological treatments, qualitative methods, theory of science.

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