The Qualitative Report

Volume 1 | Number 4 Article 1

9-1-1992

A Case for Clinical Qualitative Research*

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A Case for Clinical Qualitative Research*

Abstract

For the most part, that which is called qualitative research has been developed, understood, and justified within scientific and quantitative contexts. Sharing common interests (e.g., description, interpretation, criticism, subjectivity, etc.) with this scientific qualitative research are two contrasting traditions of research and practice, which have originated and evolved in domains of inquiry other than science and technology, namely those methods and ways of knowing from the arts and humanities, and from the clinical fields. This latter type, clinical qualitative or practitioner-generated research, is defined and contrasted with the scientific and artistic varieties. A number of clinical qualitative research projects are presented from the field of family therapy, which demonstrate how clinical inquiry may be conducted from a therapist's way of acting and knowing, or may be focused on learning more about a therapist's way of practicing and thinking in the world. Finally, implications of conducting clinical qualitative research or practitioner-generated inquiry in traditional research environments is discussed.

Keywords

qualitative research

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The Qualitative Report, Volume 1, Number 4, Fall, 1992

Abstract

For the most part, that which is called qualitative research has been developed, understood, and justified within scientific and quantitative contexts. Sharing common interests (e.g., description, interpretation, criticism, subjectivity, etc.) with this scientific qualitative research are two contrasting traditions of research and practice, which have originated and evolved in domains of inquiry other than science and technology, namely those methods and ways of knowing from the arts and humanities, and from the clinical fields. This latter type, clinical qualitative or practitioner-generated research, is defined and contrasted with the scientific and artistic varieties. A number of clinical qualitative research projects are presented from the field of family therapy, which demonstrate how clinical inquiry may be conducted from a therapist's way of acting and knowing, or may be focused on learning more about a therapist's way of practicing and thinking in the world. Finally, implications of conducting clinical qualitative research or practitioner-generated inquiry in traditional research environments is discussed.

Introduction

For the most part, that which is called qualitative research has been developed, understood, and justified within scientific and quantitative contexts (Eisner, 1981, 1991; Smith, 1987). Although this qualitative tradition is seen as an alternative to quantitative methods, it is still defined and rhetorically understood as being within science (i.e., shaped by concerns of sampling theory, validity, reliability, replication, and reactions to positivism) and as existing in a dialectic relationship with quantitative approaches: Most of this scientific qualitative research is "validated" and accepted in the sciences when presented in tandem with the quantitative side of the distinction (e.g., qualitative as pre-quantitative, as post-quantitative, and in triangulation or multi-level/multi-view configurations).

Sharing common interests (e.g., description, interpretation, criticism, subjectivity, etc.) with this scientific qualitative research is a contrasting tradition of research and practice which has originated and evolved in domains of inquiry other than science and technology, namely those methods and ways of knowing from the arts and humanities (Eisner, 1981, 1985, 1991; Smith, 1987). Although these qualitative approaches share much in common with the scientific variety of qualitative research, their existence in disciplines which do not rely on scientific ways of knowing can provide science-embedded researchers with many method choices which are not grounded in science.

Arguably, most of what is termed qualitative research in the sciences has its roots in the arts and humanities: ethnography (anthropology), hermeneutics (literary criticism/theology), discourse

analysis (linguistics and language study), deconstruction and post-modern criticism (painting/literature), etc. These methods are not usually termed "qualitative research" or are even called "research" because these practitioners do not normally define their existence and practice in concert with science and thus would not use terms which reflect an overt relationship or on-going dialogue with scientific practitioners and theorists (Eisner, 1981, 1991). For scientific qualitative researchers not to consider and explore the work of these artistic qualitative researchers, and vice versa, is a great loss for both groups, and although Eisner (1981) called for such an integration a decade ago, there still seems to be much that could be done through such co-exploration.

Clinical Qualitative Research

In addition to the scientific and artistic groups, there is a third group of re-searchers who struggle with the subjective nature of knowledge and practice and who employ descriptive, interpretive, and non-quantitative means in their work and study: the clinicians. Like their counterparts in the sciences, arts, and humanities, these clinical researchers also use qualitative methods in their research and reflection: case study, participant observation, long interviews, grounded theory, as ways of knowing and not knowing (Chenail, 1991a; Schein, 1987). Unlike the scientists and the artists, these clinicians are organized by the praxis of their work: They must use methods which produce practical distinctions which can be used in real-time decision making and/or problem solving. This style of applied research is more immediate for the clinician. As compared to the researcher conducting applied research which may be applicable to the clinical setting, the therapist's applied work is by definition applicable and relevant: It comes from the very stuff of their work. They perform and collect then they reflect and perform, again or anew. With each completion of the circle, they hope to know what they practice better or to know that they have to practice differently.

In their reflecting and re-searching, these clinicians perform their therapeutic acts and generate all their data in the everyday course of being a therapist. They reflect on these performance pieces in a "thinking out loud" manner and critique upon the particulars of the play between therapist and client. This collaborative problem-solving partnership, between the practitioner and the practice, results in therapists weighing and considering actions taken and not taken, and making adjustments and preparations for their next performance in the clinic. These researching therapists may also take on a more scientific posture and conduct more formal and systematic studies of their therapeutic practice by recording and re-viewing their sessions. Observations of these sessions may be written up and even published as clinical pieces. What remains the same between these formal and informal means of these clinicians' inquiry is that they resemble the ways and customs of scientific and artistic qualitative researchers in the prevalence of description, interpretation, and contextualization in their work.

This balancing act, between maintaining practicality for the clinical demands and drawing finer distinctions for their research requirements, is a difficult but necessary task for the clinician therapist. The more micro and detailed the analysis, the greater the richness of data produced, but this abundance of information can lead to a situation in which the researching therapist is overwhelmed by detail yet underwhelmed by the usefulness of this material. At the same time, if a therapist can analyze or reflect on an aspect of therapeutic process such that at least two parts

or phases of the bit of action can be articulated, as in the beginning and the end of that phase, then the clinician has increased the number of options that can be chosen or altered in the performance of the therapy. In other words, if the therapist as researcher can describe it, then the therapist as therapist can prescribe or proscribe it.

Creating options through analysis entails the researching or reflecting clinicians comparing and contrasting these beginnings, middles, and endings with other possible endings, middles, and beginnings in order to evaluate what they have done with what they could have done at a given time and place. Although they can never get back to that past session under scrutiny, they can approach their next therapeutic encounter with possibly one more option or choice at hand than what they had at their service during their last session.

This orientation to the clinical research process helps to make an inquiry, like clinical qualitative research, unique in its perspective and posture. Also, the relationship between these researchers and their subjects is embedded within another relationship, that of therapist to client, or therapist to patient, or even supervisor to therapist. The subject of the study could also be a client, the informant could also be the supervisor, and the co- participant with the therapist in the study could be the therapist him or herself.

These unique contexts (i.e., action-oriented/problem-solving focus and recursiveness between therapist/client and researcher/subject relationships) allows for clinical qualitative researchers to contribute different methods and theories to the scientific-artistic conversations, and conversely, to learn from the non-clinical communities. In recent years, interactions between therapists and qualitative researchers have increased dramatically in a number of the clinical fields: psychology (e.g., Hoshmand, 1989; Neimeyer & Resinkoff, 1982; Stones, 1985), social work (e.g., Allen-Meares & Lane, 1990), nursing (e.g., Leininger, 1985), and family therapy (e.g., Atkinson, Heath, & Chenail, 1991; Moon, Dillon, & Sprenkle, 1990, 1991), but despite these attempts at integration, there still persists a clinical style of qualitative inquiry or reflection which remains unique and distinct from the scientific and artistic varieties. This type of clinical approach to research can be seen clearly in the field of family therapy through a number of well-known clinical projects.

Clinical Qualitative Research in Family Therapy

In the development of family therapy, there have been a number of influential clinical qualitative research projects (Chenail, 1991a) in which researchers and therapists have imaginatively, intuitively, rigorously, and relevantly explored the application of metaphor in the study of clinical practice and theory. On one hand, these clinical projects share many similarities with other types of qualitative research, like the scientific and artistic approaches (Chenail, 1991a; Eisner, 1981, 1985, 1991; Smith, 1987) in the way description, interpretation, discovery, observation, and questioning are stressed. On the other hand, clinical qualitative research differs greatly from the scientific and artistic types in that, where scientific qualitative research is based upon a scientist's way of thinking and doing, and artistic qualitative research embraces an artist's way in the world, clinical qualitative research may be conducted from a therapist's way of acting and knowing, or may be focused on learning more about a therapist's way of practicing and thinking in the world. Although therapists may be scientific and/or artistic in their work,

performing in the context of the clinic shapes these ways of science and art into unique forms particular and peculiar only to clinicians' ways of working (see Erikson, 1958).

Given this perspective, clinical qualitative research could also be called therapist or practitioner-centered inquiry, wherein every attempt is made to match the metaphor of the therapy or therapist with the metaphor of the research or researcher. For example, if the therapy is based upon a metaphor of "therapy as narrative," then the clinical research would be conducted from a narrative perspective. Choices afforded to the researcher for reflection on this style of clinical work might include theories and methods from literary theory (e.g., Collier & Geyer-Ryan, 1990; Lentricchia & McLaughlin, 1990), hermeneutics (e.g., Chessick, 1990; Packer, 1985), or language studies (e.g., Chenail & Fortugno, 1992, May). Selection of a particular method or metaphor would be based upon a sensitivity by researchers to therapists' ways of knowing and doing their clinical practice. Clinical qualitative research could also be conducted from an emergent stance where researchers would discover (Mahrer, 1988) or create a unique method of reflection which would emerge from close, extended, and direct observations of a particular therapist's particular style of clinical work (Chenail, 1991a).

All of the clinical explorers discussed below share one fascination in common: They were curious about the ways of therapy and therapists and set about the task of learning how therapists learn and act. These explorations all were conducted through the rigorous application of metaphor to the study of therapy and therapists. In choosing and applying these metaphors (e.g., cybernetics, transformational grammar, communication theory, frame theory, etc.), these investigators had to follow three crucial guidelines of logos, rhetoric, and aesthetics: Does it make sense to juxtapose this metaphor with this phenomenon? Will the results be persuasive or compelling to both researcher and therapist alike? Will the patterns of the lens that I am using and the phenomenon I am studying connect?

In each of these cases, the projects have produced new ways of conducting therapy, as well as new ways of practicing research. Four notable endeavors in this vein have been the Gregory Bateson, Don Jackson, Jay Haley, John Weakland, William Fry, and Richard Fisch studies, the Richard Bandler and John Grinder work, the Milan-Coordinated Management of Meaning (CMM) conference, and Bradford Keeney's cybernetic project.

In the Bateson project, a rigorous study of Jackson's post-psychoanalytic work from Batesonian communication theory (Bateson, 1972, 1979) helped to produce a widely used approach to communication research as seen in works like *Pragmatics of Human Communication: A study of interactional patterns, pathologies, and paradoxes* (Watzlawick, Beavin, & Jackson, 1967), and a most popular model of brief therapy as presented in books such as *Change: Principles of problem formation and problem resolution* (Watzlawick, Weakland, & Fisch, 1974) and *The Tactics of Change: Doing Therapy Briefly* (Fisch, Weakland, & Segal, 1982). Therapists and researchers in this project shared a common view of therapy and research in that they understood both processes as being interactional and contextual. Their selection of these metaphors to study therapy remains a strong influence in the field to this day.

In the Bandler and Grinder studies, a close scrutiny of the work of Virginia Satir and Milton Erickson (Davis & Davis, 1982) from a linguistics and language metaphor (e.g., transformational

grammar) lead to the Neuro-Linguistic Programming (Bandler & Grinder, 1975, 1979; Grinder & Bandler, 1981) approach to therapy and a formal notational system for human interaction (Grinder & Bandler, 1976). Bandler and Grinder successfully matched the multi-channelled, finely textured work of Satir and Erickson with a multi- dimensional view of communication and language to produce one of the most complex methods to practice and describe therapeutic process.

In the Milan-CMM project, Karl Tomm put together a conference (McNamee, Lannamann, & Tomm, 1983) which lead to a number of projects and papers created from a juxtaposition of the circular notions of Milan therapy (Selvini-Palazzoli, Boscolo, Cecchin, & Prata, 1980) with the circularity of a communication research approach known as the Coordinated Management of Meaning (Cronen, Johnson, & Lannamann, 1982; Pearce & Cronen, 1980). As a result, Milan-style circularity in therapy took a reflexive turn with Tomm's work (1987a, 1987b, 1988), and a turn towards curiosity with Gianfranco Cecchin's therapy (1987). As for a change in research, the notion of questions as interventions in therapy (Tomm & Lannamann, 1988) helped lead to the suggestion that research questions may also be seen as interventions and possibly as therapy (McNamee, 1988).

In the Keeney experiments, the first project, a cybernetic understanding (i.e., a study of patterns) of systemic family therapists' discourse (i.e., a practice of patterns) (e.g., the clinical work of John Weakland, Jay Haley, Olga Silverstein, Charles Fishman, and Gianfranco Cecchin), produced a descriptive system for therapy, first articulated in *Aesthetics of Change* (Keeney, 1983), and then applied in *Mind in Therapy: Constructing Systemic Family Therapies* (Keeney & Ross, 1985) and *The Therapeutic Voice of Olga Silverstein* (Keeney & Silverstein, 1986); and also a prescriptive model for therapy (Keeney, 1987, 1990). With his second project, Keeney simplified his cybernetic understanding of systemic family therapists' discourse to a cybernetic understanding of discourse, based upon a recursive relationship between text and context in both the practice of therapy and observations of that therapy. This shift resulted in his improvisational approach to therapy (Keeney, 1991) and a new type of frame analysis known as Recursive Frame Analysis (Chenail, 1991b, 1991c; Fortugno, 1991, 1991, July; Keeney, 1991; Keeney & Bobele, 1989). Clinical research projects like these examples demonstrate that researching therapy through an application of practice-sensitive metaphors can produce meaningful results for both therapists and researchers alike.

Qualitative Research Combinations

The above-mentioned projects reflect just some of the many juxtapositions possible when artistic, scientific, and clinical metaphors are rigorously applied to the study of therapy. Despite the impressive results of these storied studies, the potential in these combinations has barely been tapped. One way to improve this situation is for researching clinicians and clinical researchers to examine choices that are available to them at various option points in the construction or discovery of a method or plan for reflection or research (see Morris & Chenail, 1995).

Inquiry in qualitative research takes its form from the choices made and not made by the investigator in the construction of a method or plan. For some the choice of method is quite simple: They choose an extant method such as Glaser and Strauss' (1967) grounded theory

approach or Spradley's (1979) ethnographic style and apply it to their planned study in a "follow-the-steps" fashion. For others, their method for a particular project has a uniqueness which is shaped by the particularities of the problem at hand. Following a "create-a-method" style of inquiry, this latter group of qualitative researchers may improvise on a standard method; combine aspects of one approach with another; may employ a cybernetic posture of changing the method via a feedback/calibration system throughout the course of a project; or let the method be an emergent process that is either discovered or created as the research unfolds in a "no-plan" plan fashion.

Which ever the path chosen, the researcher can weigh the strengths and weaknesses, the pragmatics and aesthetics of artistic, scientific, and clinical styles, techniques, and approaches. Whether it be in the area of perspective (e.g., positivist, constructivist, or pragmatist) or posture (e.g., artist, scientist, or therapist) of the researcher, or the generation and collection of the data (e.g., interviews of therapy participants, recordings of therapy sessions, or diaries of therapists), or the preparation and analysis of the information (e.g., transcription, discourse analysis, or intuitive musings), and finally, the presentation or performance of the results (e.g., photos of sessions, case studies, or collage of meaningful moments in therapy), the process of research affords the creative researcher some interesting, and hopefully useful research projects. When art, science, and therapy are juxtaposed, some fascinating research possibilities emerge: systematic intuition, therapy as work in progress, naturalistic sampling, annotated case studies, and transcribed streams of clinician's consciousness.

There is also some danger associated with these latter types of method construction. In the spirit of maintaining a posture of creativity and a sensitivity to making each method unique to the particular project, a certain level of efficiency and productivity may be lost in the project, or even worse, the method just might not work. In such an instance, a faulty method, that is, one which does not allow for the researcher to study what was planned to be studied, may leave the researcher with a collection of data which is "unanalyzable," or a contaminated data collection environment, or a study which lacks any semblance of coherence and usefulness. Of course that makes research an always interesting and sometimes disappointing process. Neither art, nor science, nor therapy, nor even research proceeds without some breakdowns, and it is these painful failures that often result in wonderful breakthroughs when the investigator or performer or clinician has to go back to the "drawing board." It takes great courage to reflect on our work and to make the changes necessary to improve and expand our practice and knowledge, but the results are usually more than worth the pain.

Clinical Qualitative Research as Endangered Species

The success of the research projects discussed and the bright future that other qualitative combinations hold for clinicians have paradoxically been problematic for the field of family therapy. On the one hand, this style of research has produced a number of significant and clinically relevant studies for practitioners, but on the other hand, this work of researching clinicians has not been widely recognized and accepted by many clinical researchers as "true research."

This is a not a problem unique to family therapy. For most applied fields, identity and authenticity as a discipline in academia is created and maintained through traditional research practices, production, and prowess. Research as a way of becoming accepted amongst peers in universities and their respective colleges and departments is not a bad thing, but it should not be the only reason family therapy types practice the research craft, as in a "When in Academia, do as the Academics do."

For family therapy practitioners another very important reason to engage in research is to be able to say or to know something more or different about that which they do when they practice their artistry and science. Pressure from the research establishment in the shape of publishing, presenting, funding, and academic promotion politics may help to make the variety of clinical research discussed above become an endangered species as practitioners turn away from their clinical and applied ways of knowing and adopt quantitative and overly-scientific qualitative research ways in an attempt to become legitimate researchers in the narrow way that research is defined nowadays in academia.

There exists an irony in such a turn: The practice wisdom of researchers is privileged over the practice wisdom of clinicians and therapists when it comes to valid and valued knowledge production in therapy. By placing one mode of inquiry's descriptions and findings over and above all other practices' contributions to knowing and doing, the message in academia is clear: All practices are not created equal. If there is to be dialogue between teachers and researchers, if there is to be a dialectical relationship between reflecting clinicians and clinical researchers, and if there is to be a richness of double description of clinical phenomenon, then there needs to be a plurality of method and an appreciation of all practices' ways of knowing and performing.

Many researchers have tried to remedy this perceived deficit of knowledge production on the part of therapy practitioners by creating and juxtaposing research methods which could serve as enlightening and elevating experiences for teaching and clinical practitioners and could be widely accepted by the research establishment. Be it scientific or artistic approaches, qualitative or quantitative, most of these methods ask the therapist or teacher to embrace a new way of knowing or seeing their once-familiar world. New language is needed for such a metamorphosis (i.e., therapist to scientific researcher or teacher to artistic investigator) and this new language may feel strange in practitioners' mouths and leave the teacher or therapist speechless because these people have been left dumb-founded: Their language of practice has not been privileged or appreciated by researchers and moreover, researchers would wish to substitute their own language of practice for the native tongues they find in the classroom and clinic (e.g., Goering & Strauss, 1987; Liddle, 1991). Treated as some sort of primitives, these teachers and therapists are re-schooled and re-languaged to become more acceptable as clinical researchers.

One way out of this dilemma is for these helpful researchers to take the time to listen to the therapists, teachers, supervisors, and administrators and hear how these practitioners have a re-searching or reflecting language all their own (e.g., Hoshmand, 1991; Hoshmand & Polkinghorne, 1992; Kaye, 1990; Schön, 1983; Scott, 1990). Like all language practices, these teachers' and therapists' research and reflection dialects have their own patterns of particularities (Becker, 1991): between deficiency and exuberance, between said and unsaid, and between literal and figurative (Chenail & Fortugno, 1992, May). With a little bit of patience and time,

even the most traditional clinical researcher can be able to hear and see that research is already happening in the clinic and classroom.

For their part, practitioners of this practitioner-generated research should be open to researchers, should be able to articulate their systematic and controlled reflections on practice, and should show how these careful observations, data collections and analyses, and hypotheses testing inform their practice and make for rigorous and imaginative inquiry. This special research dialect spoken by practitioners should be appreciated, studied, practiced, and circulated by practitioner and researcher alike. Instead of feeling ashamed and inarticulate, therapist and educator should be proud and loud with their language of clinical and practical reflections, and instead of having a righteous missionary zeal, researchers should approach the land of the clinic and the school with respect, openness, and curiosity. If such practice is embraced in therapy and research, then clinicians and researchers will move beyond this period of colonialism to a new era of community, cooperation, and the advancement of clinical qualitative research.

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*A earlier version of this paper was presented at the 1992 Qualitative Research in Education Conference held at the University of Georgia, January 2-4, 1992.

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