1 Qualitative research in counselling and psychotherapy: achievement and potential

In recent years, qualitative research has become increasingly influential within social science, education and healthcare research. For many people wishing to do research into real-life topics and problems in these fields, qualitative inquiry offers a set of flexible and sensitive methods for opening up the meanings of areas of social life that were previously not well understood. Qualitative inquiry holds the promise of discovery, of generating new insights into old problems, and producing nuanced accounts that do justice to the experience of all those participating in the research.

If qualitative research in counselling and psychotherapy is to make a significant contribution to the quality of services that are offered to users, it is essential for both researchers and consumers of research to possess a clear idea of the nature and achievements of qualitative research within the field of counselling/psychotherapy. The aim of this chapter is to examine the role of qualitative research in counselling and psychotherapy. A definition of qualitative research is offered. This is followed by a look at some of the achievements of qualitative research in therapy, and a discussion of the historical context in which these studies were carried out.

Defining qualitative research

What is the point or purpose of conducting research into an activity such as counselling or psychotherapy? The answer to this question is perhaps obvious. The purpose of research is to enhance knowledge, to enable us to know more about the way counselling and psychotherapy operate and how or why they are effective (or perhaps not effective). But

there are deeper questions that lie behind this type of common-sense perspective on the role of research. What do we mean by 'knowing' and 'knowledge'? It is possible to identify two broad styles of knowing that exist within Western culture and society. The psychologist Jerome Bruner (1986, 1990, 2002) has described these distinct ways of knowing as 'paradigmatic' and 'narrative'. Paradigmatic knowing is associated with positivist physical sciences and involves the establishment of abstract 'if–then' statements about the world, which seek to explain how observable phenomena are the result of specific causal factors and processes. By contrast, narrative knowing is associated with everyday accounts of human action, usually in the form of stories. We make sense of the events of our lives by telling stories to ourselves, and others, about what happened, when it happened, what each person said and did, and so on. Paradigmatic knowledge reflects an 'objective' deterministic world; narrative knowing reflects a 'constructed' world in which human agency can make things happen.

Exercise 1.1 Reflecting on forms of knowing

Take a few minutes to think about your work as a counsellor or psychotherapist. How do you know what to do in response to your clients? What are the sources of your knowledge? How adequate is the narrative–paradigmatic distinction as a means of classifying the types of knowledge that you use? What other categories come to mind, in relation to knowledge sources that are meaningful for you?

Within the academic and professional community, there has been considerable tension between these alternative ways of knowing. Paradigmatic knowledge has accrued status and influence through its use within medicine, the physical sciences and technology. Narrative knowing, by contrast, represents the domain of 'softer' (and economically less powerful) disciplines such as literature, art, anthropology and history. There have been many individuals and groups who have argued for the incommensurability of these approaches to knowledge. However, it is also possible to adopt a more pluralistic or pragmatic position (the perspective adopted in this book), which views both paradigmatic and narrative forms of knowing as essential human accomplishments that can be combined in many ways in order to serve different purposes. Within everyday life, and therapy practice, we routinely tack back and forward between narrative and paradigmatic ways of making sense of problems. For instance, if someone comes into therapy because they are struggling to come to terms with the effects of a serious car accident, then both therapist and client are comfortable with talking about the

causal, determinist aspects of what has happened (the ice on the road, the speed at which the other person was driving, the effect of the drugs taken to alleviate pain) as well as the personally and collectively constructed meaning of the event (e.g., the significance of losing one's job). Similarly, the research literature as a whole necessarily encompasses examples of both narrative and paradigmatic ways of making sense of specific issues and phenomena. And within any individual research article, there is usually a story or stories that are being told, alongside some kind of more generalized or abstract model that is being proposed.

Where does qualitative research fit into these types of knowing? The starting point for qualitative research is conversations and stories, and interpretation of objects, images and rituals that tell stories or are meaningful in some way. Qualitative research is therefore firmly rooted in the 'narrative' side of Bruner's narrative–paradigmatic distinction. However, qualitative methods can readily be used, as reflected by many examples in the chapters that follow, to generate or test abstract 'paradigmatic' cause–effect models. Qualitative research starts with language and meaning, and can reach out into the domain of numbers and 'variables'. Quantitative research starts with numbers and causal linkages between variables and can reach out into the domain of stories. Mixed methods research seeks to harness both forms of knowing at the same time. The key point here, and the underlying philosophy of this book, is that for practical purposes, qualitative/narrative and quantitative/paradigmatic forms of knowing complement each other. They are both necessary. This is particularly important within the field of research into counselling and psychotherapy. A knowledge or evidence base for therapy that consisted only of qualitative findings, or only quantitative findings, would be like thinking with one hemisphere of the brain anesthetised – it can be done, sort of, but it is not very effective.

There are many definitions of qualitative research that can be found in textbooks and in the writings of leading figures in this field. I would like to offer my own definition, that I believe is particularly attuned to the needs and interests of therapy researchers and practitioners. In my view, qualitative methods contribute a particular kind of knowledge about the world, which can be summed up in these terms: *the primary aim of qualitative research is to develop an understanding of how the social world is constructed*. The notion of the world being 'constructed' implies that we inhabit a social, personal and relational world that is complex, layered and can be viewed from different perspectives. All of this is the result of human activity. We construct our world through many forms of individual and collective action: talk and language (stories, conversations), systems of meaning, memory, rituals and institutions, and all the myriad ways in which the world is physically and materially shaped by human purposes. The various qualitative methodologies that have been

devised, and that are introduced in later chapters, all seek to contribute to an understanding of how the world is constructed, but each of them takes on a different facet of this task. For example, some qualitative research focuses on the meanings through which people construct their realities. Other researchers concentrate on the way that shared cultural worlds are constructed through ritual, myth and social practices such as kinship rules. Still other researchers seek to make sense of how reality is constructed through talk and language use. Finally, there are qualitative researchers who are interested in challenging existing structures of understanding (*de*-constructing) or in building new ways of doing things (*re*-constructing).

This is why qualitative research is so useful for therapy. It is certainly important to have access to paradigmatic cause-and-effect knowledge, such as the finding that cognitive-behavioural therapy (CBT) is more effective than other forms of therapy with clients experiencing panic disorder. But that CBT intervention consists of therapists and clients who each act as purposeful, intentional agents on the basis of their different meaning systems, who engage in conversation around what the problem is and what can be done, and whose meetings are located within and shaped by complex cultural and organisational systems. Qualitative research holds the promise of opening up these multiple levels of construction for deeper scrutiny. The following section offers some examples of how this promise has begun to be fulfilled.

Box 1.1

Tracing the growth in qualitative research

Historically, counselling and psychotherapy research has been dominated by the methods of inquiry used within the disciplines of psychology and psychiatry, such as standardised measurement instruments (tests), diagnostic categories and experimental designs. Compared to the amount of quantitative research that has been produced, relatively little qualitative research in counselling and psychotherapy is being published. Analyses by Rennie, Watson and Monteiro (2002) and Marchel and Owens (2007) of all articles in journals published by the American Psychological Association (APA) reported that between 0.45% and 1.3% (depending on the search strategy employed) of all articles were qualitative studies. The majority of these qualitative studies were published in psychotherapy and counselling psychology journals (Munley et al. 2002). In these therapy journals, less than one quarter of published studies used qualitative methods, although the proportion of qualitative studies had increased in recent years. In the UK, the reporting of qualitative research has been promoted by two journals – *Psychology and Psychotherapy: Theory, Research and Practice* and *Counselling and Psychotherapy Research*. Of the research studies published in these journals during 2009, the proportion of research studies using qualitative or mixed methods was 81% (22/27) for

Counselling and Psychotherapy Research and 27% (8/30) for *Psychology and Psychotherapy: Theory, Research and Practice*. In *Psychotherapy Research*, a journal with an explicitly international readership, the proportion of qualitative studies in 2009 was 17% (5/29), and in the *Journal of Counseling Psychology* (American Psychological Association) the proportion was also 17% (8/48).

The achievements of qualitative research in counselling and psychotherapy

The studies that are highlighted below are offered as examplars of the kind of enhanced knowledge and understanding that can be achieved through the use of qualitative inquiry. It is necessary proceed with caution to interpreting the significance of these studies. As outlined in Box 1.1, there is still only a relatively small amount of qualitative therapy research that is being published. At this point, there are few areas of therapeutic endeavour in which there exist enough published studies to carry out meaningful meta-analysis or meta-synthesis that integrates the findings of multiple studies on the same topic. The studies that are discussed here are therefore examples of what can be accomplished with the use of qualitative methods, rather than indicating conclusions that can be generalised.

- *Clients report different outcomes from different types of therapy*. Research into the outcomes of therapy is hugely important within the field, because clients, taxpayers, health service managers and other groups of people are vitally interested in knowing 'what works'. Many hundreds of quantitative outcome studies have been published (for an overview of this literature, see Cooper 2008). For the most part, the results of this vast investment in scientific activity has yielded a puzzling finding – the *equivalence paradox*. Research seems to show that very different types of therapeutic intervention, when compared to each other in a fair test, appear to have the same level of success. A qualitative study carried out in Sweden by Thomas Nilsson, Martin Svensson, Rolf Sandell and David Clinton (2007) produced findings that begin to explain why the equivalence paradox exists, and what it means. Nilsson et al. (2007) interviewed clients who had received either CBT or psychodynamic therapy. Their analysis of the interview transcripts uncovered a great deal of interesting information about how these clients had experienced the therapy they had received, but in relation to the equivalence paradox two particular findings were particularly relevant. First, among the clients who reported that they had benefitted from therapy, quite different types of learning were described by those who had received CBT, compared to those

who had received psychodynamic interventions. The CBT clients stated that what had changed was that they were now better able to deal with difficult situations and had taken control over their lives. By contrast, the psychodynamic clients said that what had changed was that they could understand themselves better, and could set limits and boundaries in their relationships with others. Both groups of clients had improved to the same extent in terms of symptoms of anxiety and depression, but had changed in different ways. Second, among the clients who had not been helped by therapy, those who had received CBT complained that they had been disappointed that their therapist had not allowed them to talk more extensively about their emotions and relationships (i.e., had been more like a psychodynamic therapist), while those who were disappointed with their psychodynamic therapy stated that what they had really wanted was someone who would provide structured problem-solving (i.e., a CBT therapist). When contrasted with the evidence accrued from quantitative outcome studies, the Nilsson et al. (2007) study opens up a more nuanced, and potentially more practically useful, account of therapy outcome, one that begins to uncover the ways in which the benefits of therapy are shaped by the interplay between the meaning systems of client and therapist around what is helpful.

- *How therapists control the therapeutic agenda.* Part of the legacy of Carl Rogers is the idea that counselling and psychotherapy are, or should be, fundamentally *client*-centred, in the sense of respecting and working with the way that the client defines his or her problem, rather than imposing an external, expert-drive perspective. There have been several qualitative studies that have challenged this idea by looking at what actually happens in conversations between clients and their therapists. One of the clearest and most convincing studies of this type was carried out in Holland by Kathy Davis (1986). In this study, an analysis was conducted of the conversation during the first meeting between a client (a young woman) and an experienced and highly regarded male therapist. The transcript of this session reveals that the client begins by describing the difficulties in her life (two young children, lack of contact outside the family, some tension with her husband). During the opening phase of the conversation, the therapist reflected back what the client is saying, and encouraged her to keep talking. As the session proceeds, however, the therapist introduced a gradual *reformulation* of the problem, redefining it as an issue around maintaining a façade and not being able to be open about feelings. Careful analysis of the conversational interaction was able to identify ways in which the therapist led the client into an agreement with his way of defining her problem. Davis (1986) comments that it took her a long time to be able to 'see' what had been happening in this session – on the face of it, what

was in the transcript seemed to be an example of a typical good first meeting. It was only through detailed line-by-line analysis of the ways in which meaning was constructed and reconstructed through various conversational strategies that it became apparent that what was happening reflected a high level of therapist professional control of the interaction, in the direction of a therapeutically-tractable problem definition. Another study that arrives at a similar conclusion is Antaki, Barnes and Leudar (2007).

Exercise 1.2 Reading qualitative research

How much do you draw on qualitative research to inform your practice as a counsellor or psychotherapist? Identify a topic that is relevant to your practice. This could be a therapy process concept (e.g., self-disclosure, empathy, contracting) or a type of presenting problem (e.g., depression, work stress). Using an online search tool to which you have access (e.g., Google Scholar, PsyInfo, Web of Science) enter the key word or phrase that best captures your interest, along with 'qualitative research'. How useful and interesting for you are the articles that you find?

- *Entering the lived experience of clients with different types of problem.* One of the challenges of being a counsellor or psychotherapist involves entering the worlds of people who are struggling to cope with issues that the practitioner has not come across before in their personal or professional life. Good therapists are empathic and curious, and work collaboratively with clients in order to at least begin to understand the reality of their worlds. But it is also useful to draw on external sources of information. Qualitative research can be an invaluable source of insight into the experiences of people who are living with specific problems. For example, in the area of acquired brain and spinal cord injury, Andrew Sparkes and Brett Smith (2006) and Masahiro Nochi (1998, 2000) have explored the ways in which the person's self-narrative can be changed for ever by a chance event, such as a sporting or industrial accident, and how people in this situation are eventually able to construct a new narrative and different relationships. For any therapist working with a client who is suffering from acquired brain injury, reading these qualitative studies will sensitise them to the possible ways in which their client may be thinking and responding, and the ways that other people may be relating to them. This kind of research does not look at the process or outcome of counselling or psychotherapy, but provides therapists with essential background information. Within the qualitative research literature, there are studies that have looked at the lived experience of people undergoing a wide range of health conditions and social problems. The findings of these studies represent an

invaluable resource for the therapist, as a means of tuning in to the unique experience of individual clients and as a basis for designing interventions for groups of clients.

- *What are the characteristics of good therapists?* There have been a number of large-scale quantitative studies into the outcomes of therapy that have found that there are quite wide variations in the effectiveness of individual therapists who are randomly allocated clients of equivalent levels of problem severity. In particular, there appear to be a small number of therapists who are markedly more effective than their colleagues. What is it about these star performers that makes them able to achieve such high success rates? Thomas Skovholt and Len Jennings (2004; Jennings and Skovholt 1999) asked therapists in the region in which they worked to nominate those colleagues whom they regarded as 'the best of the best' – the therapists to whom they would refer close friends and family members. Skovholt and Jennings (2004) then identified a set of 'master therapists', each of whom had been nominated by several colleagues, and invited them to take part in an in-depth interview that explored all aspects of their careers and their approach to their therapeutic work. What they found was that these master therapists were voracious learners. Even if they defined themselves as working within a specific therapeutic approach (e.g., CBT, family therapy), they were endlessly curious about the human condition, and read widely around all therapy approaches. This appetite was learning was not a by-product of having academic roles – all of the master therapists in the study were in private practice. Another recurring theme in the interviews was that master therapists were unusually open to receiving feedback in relationships, and using this information to guide their own personal development. This line of research has significant implications for the training, supervision and lifelong learning of therapists. It also demonstrates how quantitative and qualitative methods of research can complement each other in the inquiry process.

- *Developing a more comprehensive understanding of the therapeutic relationship.* The central role of the quality of the client–therapist relationship, as a factor in effective therapy, is widely acknowledged. An extensive body of theory and research into the therapy alliance and the repair of ruptures in the therapy relationship has accumulated in recent years, almost entirely based on clinical observation by therapists and the use of quantitative measures of relationship dimensions. Qualitative research that has explored the views of clients in terms of how they have experienced their relationships with their therapists has both challenged and extended existing understandings. In a study carried out by Rob Bedi, Michael Davis and Meris Williams (2005), therapy clients were asked to describe incidents in their therapy that had contributed to the strengthening of

the relationship. Some of the things that were mentioned by clients reflected themes within the therapy alliance literature. However, many other types of critical incident were described that did not correspond with prior theory and research. For example, clients said that when the therapist introduced a technique, it showed that he or she cared about the client. Some of them described acts of kindness, such as the therapist serving tea and snacks at the start of a session. Others reported that the way the therapist dressed, or how their room was furnished, helped to make a good connection. The underlying themes in many of these incidents was that clients wanted to know that their therapist actively cared about them. In another study, Constance Dalenberg (2004) asked clients who had been angry with their therapists about what they had wanted from the therapist at that point, and how they felt about what had in fact been offered. What these clients said was that they felt hurt and even more angry if the therapist retreated behind a professional mask in response to their anger, and felt able to begin to make sense of their feelings if the therapist acknowledged their own role in what had happened. These relational themes of therapist care and emotional honesty were also found in a study by Heidi Levitt, Mike Butler and Travis Hill (2006) that explicitly aimed to develop therapeutic principles based on what clients said about what was helpful or unhelpful for them in therapy.

- *Identifying the phenomenon of therapist sexual and emotional exploitation of clients*. Within the current world of therapy, sexual contact between therapists and their clients is regarded as unethical and harmful. However, from a historical perspective, an awareness of the potential destructiveness of therapist–client sexual intimacy only began to emerge in the 1980s. The catalyst for this shift was the qualitative research carried out by a feminist therapist, Phyllis Chesler (1972), in which she interviewed women who had been sexually exploited by their therapists. It was this 'whistle-blowing' study, published in what turned out to be a best-selling book, *Women and Madness*, that eventually resulted in the publication of professional codes of conduct for therapists.

- *The significance of metaphors in therapy*. A programme of research by Lynne Angus and her colleagues Brian Rasmussen and David Rennie (Angus 1996; Angus and Rennie 1988, 1989; Rasmussen and Angus 1996; Rasmussen 2000) has made a unique contribution to our understanding of some of the ways in which the use of metaphor can facilitate the therapeutic process. In their research, Angus and Rasmussen tape-recorded therapy sessions, and then invited the client and the therapist to listen to sections of the tape in which vivid metaphors were used, commenting on their experience during these events. What they found was that the use of metaphor strengthens the collaborative relationship between counsellor and

client, and helps them both to represent important issues in therapy. They also found that the use of metaphor can help to deepen the client's engagement in the therapy process.

- *The failure to overcome cultural barriers in counselling.* There have been huge efforts, within the counselling profession in the USA, to overcome cultural barriers to therapy, by implementing a vigorous programme of research and training in multicultural ways of working. In the light of these efforts, two qualitative studies, based on interviews with African-American clients and members of the public, have generated some interesting findings (Thompson, Bazile and Akbar 2004; Ward 2005). In both of these studies, African-American participants reported that they believed counselling could potentially be valuable for them, but believed that therapists were insensitive to the African-American experience, and that therapy services were generally not accessible to members of their communities.

- *How therapy theory and practice has been shaped by cultural and economic factors.* It is easy to take for granted the place of counselling and psychotherapy as established professions and institutions that are widely used by people in modern industrialised societies. However, the talking therapies only really became generally accessible to the general public in the post-Second World War era. Philip Cushman (1990, 1992, 1995) has examined the social and cultural factors which have shaped the evolution of therapy and its rise to prominence. His key book, *Constructing the Self, Constructing America: A Cultural History of Psychotherapy* (Cushman 1995), is a qualitative analysis of historical texts stretching from the 1730s (Protestant revival meetings) to the 1960s (self-liberation through consumerism: post-Second World War object relations theory, and self psychology). His conclusion is that social mobility, consumerism and other cultural aspects of early twentieth-century capitalism resulted in the development of an 'empty' self that was filled by consumer goods and therapeutic exploration of 'inner frontiers'. What Cushman (1995) makes clear is that an understanding of therapy requires not merely thinking about the way that it impacts on individual clients, but also thinking about the way it functions as a channel of expression for broader cultural forces, and in turn reinforces these forces.

These accomplishments of qualitative research in counselling and psychotherapy represent just a few of the hundreds of valuable qualitative studies that have been published over the last thirty years. These exemplar studies illustrate the *discovery-oriented* role of qualitative research. Their aim is not to test or confirm existing theories, but to push the horizon of understanding a little further by pursuing open-ended questions, and following the data wherever it leads. These studies also illustrate the way that good qualitative research is always grounded in samples of concrete

everyday-life experience, such as statements that a person might make in an interview or a transcript of a conversation between a therapist and client. These studies generate interesting new ideas, but they are ideas that emerge from close analysis of recognisable chunks of everyday interaction. Finally, the underlying image of the person that permeates these studies is that of an active, purposeful, relational being.

Box 1.2

Qualitative research and the humanisation of healthcare

Healthcare is increasingly delivered though large bureaucratic systems, in which the decisions of practitioners are tightly controlled by clinical protocols and algorithms. A common patient experience in consultations with doctors and nurses is that the health professional spends more time looking at a computer screen than looking directly at the patient. In response to these tendencies, there has emerged a broad awareness of the necessity to retain a 'person-centred' approach, and to find ways to 'humanise' healthcare provision. Len Todres, Kathleen Galvin and Immy Holloway (2009) have argued that qualitative research can play a central role in the humanisation of healthcare by generating knowledge that is informed by core humanistic values. They point out that, on the whole, qualitative research is highly effective in documenting and affirming the humanising practices listed in their model, and critically challenging the dehumanising ones. They suggest that their model provides the basis for the qualitative research agenda – in relation to any specific healthcare issue, qualitative studies are needed around all of these value domains (see also Dahlberg and Halling 2001).

Table 1.1 Humanising and dehumanising values in healthcare research

Forms of humanisation	Forms of dehumanisation
Insiderness	Objectification
Agency	Passivity
Uniqueness	Homogenisation
Togetherness	Isolation
Sense-making	Loss of meaning
Personal journey	Loss of personal identity
Sense of place	Dislocation
Embodiment	Reducing the body to biological processes

The historical context of qualitative research in counselling and psychotherapy

The methods of inquiry espoused by a discipline are related to the stage of historical development that it has attained. At the beginning of the

formation of a discipline, the requirement is for descriptive research, usually in the form of case studies, which function to establish the parameters of the discipline, define its key questions and knowledge domain, introduce concepts, document what pioneers are up to, and generally persuade the appropriate audiences that this new discipline is something distinctive and worthwhile and deserving of support. Then, as the discipline or profession becomes established, research moves towards consolidating the *status quo*. Kuhn (1962) has called this 'normal science'. The basic product is known, and the task now is to look at some of its properties with the aim of refining and improving it. The criterion for good 'normal' research is not that it is persuasive or innovative (as in the previous stage in the history of the discipline) but that it is reliable and repeatable.

The movement from stage one (forming the discipline or profession) to stage two (consolidation and routinisation) is only possible if institutional and statutory approval is obtained. Danziger (1990, 1997a) has documented some of the moves in this process in relation to the establishment of psychology as an academic discipline in the period from 1870 to about 1930. Danziger points out that at the beginning of this period there existed a diversity of approaches to psychological inquiry, whereas by the end the method of laboratory experimentation and statistical analysis of data was dominant. For example, in the 1870s Wundt and other German investigators were carrying out studies in which the roles of researcher and 'subject' were interchangeable, and introspection was used as a method for gathering data. By the 1930s very few studies of this type were being conducted or reported. Psychology had established itself by adopting the methods of the natural sciences, which included the assumption of passive 'objects' of investigation.

A similar process can be seen to have taken place in psychotherapy. The pioneers of psychotherapy, such as Freud and Rogers, used case reports both to explore the nature of how they worked with clients, and to publicise their approach. It was only in the 1950s and 1960s that research into both client-centred and psychoanalytic psychotherapy became 'routinised', through the development of quantitative self-report process and outcome measures which are still in use today. Due to the existence and influence of quantitative methods in psychology, by the time that counselling and psychotherapy research was beginning to flourish (in the 1950s), it was inevitable that it would adopt that kind of methodological framework, A useful account of historical trends in the evolution of psychotherapy research can be found in Russell (1994).

The type of research that was carried out in counselling and psychotherapy has also been shaped by the political context. Although psychotherapy existed in the period 1890–1950, its main expansion took place in the latter half of the twentieth century. From the 1940s through

to the 1970s the main professional associations were formed, and the principal models of practice and settings for practice were established. During this time, leading figures and institutional groups in counselling and psychotherapy have continuously worked to demonstrate the legitimacy of psychotherapy in the face of professional rivalry from psychiatrists, social workers and to some extent clergy, and in the face of a background of scepticism from some sectors of the public (see Hasenfeld 1992). Counselling and psychotherapy have needed to fight to establish their credibility and status in a culture where many people believe in biological explanations of character and conduct, or equate emotion with weakness. At the same time, psychotherapy has been internally divided, into competing approaches or schools of thought. These schools have sought legitimacy in relation to each other in a variety of ways, including the use of research findings to demonstrate their effectiveness, to signal their acceptance of rational, scientific values, and to ease their entry into the academy.

The importance for the counselling and psychotherapy community of these two forms of legitimacy – external and internal – has resulted in a preference for forms of knowledge-making that have been primarily concerned with being able to convince other people of the truth of statements already believed by the inquirer to be true. Therapy research has sought to establish the plausibility of statements such as 'therapy relieves the symptoms of depression in the majority of cases' or 'the type of therapy we practise here is particularly effective because…'. The kinds of research articles that have been published on therapy (the official scientific knowledge base) rely heavily on a rhetoric of facticity and objectivity, with the methods section often being the lengthiest part of a research paper. It is seldom that psychotherapy researchers report 'discoveries' such as new phenomena. In psychotherapy, the discoveries, such as they are, arise in practice, and the role of research has been to verify or 'test' them.

All research in the psychological and social sciences can be viewed as comprising an interplay between verification and discovery. The motivation for embarking on a piece of research arises from some mix of a wish to be able to demonstrate that already known propositions are true (verification) and a wish to generate new propositions about the world (discovery). Even in the most hypothesis-driven experimental research, a failure to support the hypothesis can be seen as a discovery, a first step in the direction of a new proposition about the phenomenon being studied. Conversely, in even the most discovery-oriented qualitative studies, findings will not be plausible unless they are to some degree 'obvious', in affirming at least some aspects of taken-for-granted everyday reality. Radical qualitative inquiry which seeks to deconstruct everyday reality must still verify enough of the routine and the familiar to make

sense to readers. However, although verification and discovery are *both* present in all research, the relative emphasis given to one or the other differs according to the aims of the investigators. In psychotherapy research, the goal of verification has prevailed for a considerable period of time for two reasons. First, as already mentioned, verificationist research is an effective strategy for building legitimacy. Second, the academic disciplines that have hosted the bulk of therapy research – psychology and psychiatry – have been dominated by hypothesis-testing, experimental research designs.

These are some of the historical factors that have led to therapy research being dominated by quantitative measures and quasi-experimental research designs. But things are beginning to change. Although policy-making in healthcare systems is still largely influenced by evidence from quantitative studies, there is a growing appreciation that effective service planning also needs to heed the voices of consumers and service users, and that qualitative research offers a reliable means of representing these views. Also, the rigidity of the divisions within therapy into competing schools or approaches is dissolving as more and more practitioners describe themselves as 'integrationist' in theoretical orientation. There is therefore less interest in proving that one brand-name therapy is more efficacious than the next one, and more interest in discovering what is effective across all therapies. The consolidation and expansion of counsellor and psychotherapist training in universities has meant that staff members have been exposed to a variety of different modes of research and inquiry through contact with colleagues in faculties and departments other than psychology. The emergence of 'post-psychological' therapies, such as feminist therapy and narrative therapy, has opened a bridge between mainstream therapy research and the alternative forms of inquiry practised within these new approaches. Finally, increasing numbers of therapists are receiving training in research methods, and are seeking to carry out research that is relevant to practice. For many of these practitioner-researchers qualitative research represents the methodology of choice.

These factors have combined to contribute to the emergence of a rhetoric of *methodological pluralism* in the psychotherapy research community. A seminal paper by Howard (1983) acknowledged the value of a diversity of research approaches, encompassing qualitative as well as quantitative methods. A highly significant signal of the acceptability of qualitative methods came in the fourth edition of the authoritative *Handbook of Psychotherapy and Behavior Change*, published in 1994, in which the editors and some contributors publicly asserted the value of methodological pluralism (Bergin and Garfield 1994). Methodological pluralism is now fairly established as a core principle within the counselling and psychotherapy research community, with a mix of quantitative,

qualitative and mixed methods papers being routinely presented in conferences and journals, and in doctoral dissertations. However, qualitative therapy research has a lot of catching up to do. Relatively few therapy researchers and research supervisors possess experience and skills in qualitative research. In addition, qualitative research in therapy lags behind qualitative research in other professional fields, such as education and nursing. Contemporary debates around qualitative methods make little mention of therapy research. For example, the authoritative *Sage Handbook of Qualitative Research* (Denzin and Lincoln 2005a) includes only one chapter written by a psychologist or counsellor/psychotherapist.

Box 1.3

Where qualitative research fits in to research policy

The research that is carried out into counselling and psychotherapy, and the funding that is available to support that research, is influenced by the views of government policy-making bodies regarding the types of research that should be prioritised. In Britain, the Medical Research Council (MRC 2008) has published guidelines for the evaluation of complex inrterventions, such as counselling and psychotherapy, that stipulate that qualitative studies and case studies should be undertaken to map out relevant dimensions of the intervention, in advance of large-scale randomised trials. Qualitative studies are also recommended to examine the effects of proven interventions on sub-groups of patients. Also in Britain, the recent National Institute for Health and Clinic Excellence (NICE) review of research into non-pharmacological treatment for depression (National Institute for Health and Clinical Excellence 2009) includes a section on qualitative evidence. It is important to acknowledge that qualitative evidence has not had a decisive impact on these guidelines (or other official guidelines and clinical protocols), but that is because there has been a lack of high-quality relevant qualitative studies, not because qualitative research has been excluded from the debate. Although the role of qualitative research in relation to policy objectives varies from country to country, there are certainly some international examples of the qualitative research in therapy being taken seriously.

Conclusion: the role of qualitative methods in counselling and psychotherapy research

Qualitative research represents a form of narrative knowing, grounded in everyday experience, that has the potential to make a significant and necessary contribution to the evidence base for counselling and psychotherapy. As demonstrated earlier in this chapter, although relatively few qualitative studies have been published in the field of counselling and psychotherapy, compared to the number of quantitative studies, there

are already several examples of qualitative studies that have had a major impact on our understanding of therapy process and outcome. The counselling and psychotherapy profession has arrived at a point at which there is a general appreciation of the value of qualitative research, which is reflected in an increasing proportion of qualitative studies being conducted and published.

Looking ahead, it is possible to identify a central role for qualitative research in enabling the therapy profession to respond to current and future challenges. Modern society is characterised by a literate citizenship and open access to information. The language and concepts of therapy become incorporated into everyday discourse, and as a consequence lose their capacity to provide therapy clients with a fresh and challenging vantage point from which to view their problems. In parallel, therapy itself appropriates and reworks the dominant and silenced discourses of the culture within which it is located. It is essential that therapy continues to 're-invent' itself. Qualitative research can play a part in documenting, stimulating and evaluating this ongoing, dynamic, cultural process.

Counselling and psychotherapy exist at the intersection of liberation and social control. The unique personal/professional relationship that develops between client and therapist contains within it the potential to assist the person to be fully human in the sense of getting closer to the values and relationships that reflect their idea of the good life, and to participate meaningfully as a citizen. However, the intensity of this relationship also introduces the potential for manipulation. There are social forces, including both the state and commercial organisations, who may have an interest in co-opting therapy and therapists as agents of social control. There is a steady drift in the direction of further regulation, professionalisation and state licensing that brings with it increased pressure for therapy to become a means of social control. The continual reconstruction of therapy involves devising ways of resisting this external control and appropriation, and retaining the liberatory potential of counselling and psychotherapy. Qualitative research in therapy contributes to this potential by opening new understandings of the power relationship between client and therapist.

For the most part, the types of counselling and psychotherapy that are practised today are the products of modernity, and reflect the values and worldview that have driven the expansion of modern industrial society: rationality, the primacy of scientific knowing, individualism, globalism, progress, militarism, avoidance of risk, heterosexism, mastery. It is becoming increasingly apparent to many people that this constellation of beliefs and constructs omits many central aspects of humanity: emotionality, faith, spirituality, community, tradition, mystery, respect for the natural environment, diverse sexualities. The reconstruction of therapy

involves finding ways of incorporating these areas of experience into therapeutic practice. Here, the contribution of qualitative research lies in its capacity to approach research topics from a perspective of openness to different voices, a willingness to examine the historical 'archaeology' of therapeutic knowledge and an ability to challenge and deconstruct prevailing therapeutic language and assumptions.

The relationship between counselling/psychotherapy and society is one in which therapy is continually reconstructed in response to changes in culture and society. Qualitative research is a form of knowing that is particularly attuned to the study of how aspects of social life (such as counselling and psychotherapy) are constructed and reconstructed. As the reconstruction of therapy has become more pressing, resulting from the impact of forces such as postmodernism, multiculturalism, consumerism and changes in healthcare governance, the need for qualitative research has grown. It can be argued that the present era in counselling and psychotherapy research is beginning to move beyond legitimation and verification and into a stage of discovery, adaptation and innovation.