Chapter 1

Phenomenology: Bridging the Practice–Research Divide?\(^1\)

We need an imaginative, even outlandish, science to envision the potential of human experience . . . not just tidy reports. (Braud & Anderson, 1998, p. xxvii)

Therapists of all modalities are increasingly exhorted to undertake research. We are pushed to be accountable, to provide evidence of our effectiveness and to draw on ‘evidence-based practice’ to improve the quality of our services. We may even be threatened with funding cuts and the withdrawal of our services if we fail to use and produce research.

But research can seem remote from, even irrelevant to our practice. Dry language and impenetrable jargon can make academic journal articles confusing, even boring. Much research around seems to be carried out by postgraduate researchers far removed from everyday experiences of work with patients and clients. Clinicians are often short of time, research experience, support and confidence; and this makes the very thought of undertaking research a daunting prospect.

How can the chasm that lies between clinical practice and academic research be bridged? How can research be made relevant to practice so that clinicians actively rejoice in the integration of research findings into their practice? How can research benefit from the insight and understanding of experienced clinicians?

These are wide-ranging questions and only partial or provisional answers can be offered here. There is not the space to address the politics involved to
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do with money and power (such as the way that policy-driven research may be more about cost cutting and ideologically driven research may be more to do with defining one group as more deserving than another). Instead, this chapter seeks to demonstrate how phenomenology might build helpful bridges between practice and research.

I start by considering some general links between practice and research. The ‘chasm’ may be smaller than it sometimes feels. The following two sections discuss the implications of using qualitative research and phenomenology to bridge the divide. Phenomenology, I argue, focuses on issues of concern to therapists and therefore offers valuable knowledge to the profession. Also it nests easily with the skills and professional values of our practice. A research example is offered to demonstrate the potential of phenomenology as a research methodology for therapists.

Research For and In Practice: Linking Therapy and Research

I had a client recently who was challenged by chronic fatigue and struggling to cope with her life. In my effort to better understand her needs and experience, I investigated what current research was saying about the condition, with its profound interlacing of physical and emotional factors. My client was also seeing a complementary therapist and I wanted to learn more about how we could work together. I began by conducting a literature search, with the aim of finding out more about chronic fatigue.

My client had explained the impact of her condition on her daily life activities. She told her story and I listened – both to what she was saying and to her underlying meanings, to the things she was not saying. I checked out my own evolving understandings with her, and sought to help her describe the experience in richer detail.

In short, I engaged a process of reflective enquiry. Together we were ‘doing therapy’ but there was also a sense in which it was ‘re-search’, or searching again. McGuire (1999) well captures these twin dimensions:

Every counsellor is a researcher: for every time we form an understanding of what is going on for a client, and work with that, we are testing out a hypothesis, and altering our activity in the light of evidence (1999, p. 1).

Here McGuire is referring specifically to counselling but in my view the words apply to every therapy field. Every time we seek to know and understand more about our service users, we are doing research. Every time we reflect upon and evaluate our therapy practice, we are doing research. Every time we take part in auditing our service, we are doing research.
These therapy skills and qualities are directly transferable to the research domain – and vice versa. Both therapy and phenomenological research involve a journey of evolving self–other understanding and growth. They involve similar skills, values and interests, like interviewing skills; critical, reflexive intuitive interpretation; inferential thinking; bodily awareness; and a capacity for warmth, openness and empathy: these are all qualities needed in both therapy practice and qualitative research (Finlay & Evans, 2009). The spirit of the holistic goals we strive for, such as enabling people through rehabilitation to re-enter their ‘real world’ away from hospital or clinic, and our focus on an individuals’ everyday ways of being, doing and functioning are entirely phenomenological in spirit.

The reverse applies too. Some research approaches offer techniques and concepts that can be usefully imported back into therapy. For example, Moustakas (1990) sees his heuristic phenomenological research method, utilizing techniques of self-searching and self-dialogue, as being directly applicable to practice in the form of ‘heuristic psychotherapy’. Gendlin’s concept of ‘felt-sense’ has a direct application in both therapy and research. Narrative-phenomenological methods have been applied as a form of enquiry in therapy (e.g. Angus & McLeod, 2003) and have influenced the evolution of occupational therapists’ clinical reasoning (Mattingly, 1998; Mattingly & Fleming, 1994). Also, practice in narrative research has morphed into the practice of narrative therapy (White & Epston, 1990).

Therapists like us, therefore, have distinct advantages over other professionals when it comes to learning about and doing research. With the valuable professional competencies we bring to qualitative or phenomenological research (Finlay & Evans, 2009) we are indeed wanted and needed in research. Further, research stands to be enhanced considerably by our contribution.

If you have been hesitating to cross the bridge between therapy practice and research, I urge you to stride forth. But be warned, you need to choose your route through research territory with care. As for any journey, you need to plan and perhaps get some advice before starting off as there are challenging choices to make (Finlay & Ballinger, 2006). Thinking through the following questions should help you plan your route: What kind of evidence would best show the value of the work you do? What type of evidence should service users and funders rely on to make their choices? Perhaps most importantly, what kind of research are you drawn to and do you want to do?

**Choosing the Qualitative Route**

The prevailing view of the evidence-based practice movement is that evidence should be ‘scientific’ and that the best – indeed the only – way to
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achieve this is through rigorous measurement of (observable) behaviour and the use of standardized protocols and quantification.

This view is erroneous; in fact there are other choices that can be made. While quantitative outcome studies have much to recommend them, they are not the only ways to evaluate our practice and explore the value of therapy. As therapists, we know instinctively that some things cannot be sensibly measured or quantified. Measured outcomes do not necessarily reflect the value of our work or inform our practice. Our interests go beyond simplistic behavioural evaluations and qualitative research provides a possible answer.

Qualitative research illuminates the less tangible meanings and intricacies of our social world. Applied to the therapy field it offers the possibility of hearing the perceptions and experience of service users. How do service users experience their health and well-being? What does their illness or disability mean to them? How do they understand and experience therapy? What factors do they see are beneficial? How can in-depth understanding of one patient's experience be presented so as to give insight that informs future practice? And, what do therapists think and feel? What is their experience? How do they understand the processes involved in therapy?

In order to better understand the value of qualitative research we need to begin by considering the ways in which it differs from research based on quantitative methods and approaches – see Table 1.1.

Qualitative research aims to be inductive and exploratory, typically asking ‘what’ and ‘how’, and posing questions related to description and understanding. Quantitative research, in contrast, seeks to explain and ‘prove’. Hypothesis-testing is used with the aim of proving or disproving:

<table>
<thead>
<tr>
<th>Qualitative</th>
<th>Quantitative</th>
</tr>
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<tbody>
<tr>
<td>Aims</td>
<td>Investigates causal relationships and tests hypothesis aiming to prove or disprove scientifically</td>
</tr>
<tr>
<td>Method</td>
<td>Natural science: primarily experiments and surveys</td>
</tr>
<tr>
<td>Researcher’s role</td>
<td>Researcher is objective, neutral and detached</td>
</tr>
<tr>
<td>Findings</td>
<td>Uses words and creative arts</td>
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Table 1.1 Contrasting qualitative with quantitative research.
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it asks, for example, ‘why’ or ‘whether’ one treatment is more effective than another.

In method, too, there are important differences. Qualitative research is a human science rather than a natural science. It explores the textured meanings and subjective interpretations of a fluid, uncertain world. It uses interviews, participant observation, focus groups, creative/projective techniques, reflection and first person writing or diary studies. Quantitative research, in contrast, strives for objectivity. The methods employed are more straightforward and usually involve either experiments (for instance, comparing the results of treatment group A with control group B) or attitude surveys and questionnaires.

The researcher’s role differs too. In qualitative research the relationship between participants, researchers and their wider social world is actively acknowledged. The researcher recognizes his or her central role in a co-construction of tentative data and is required to explore these dynamics reflexively. Quantitative researchers, on the other hand, assume themselves objective outsiders looking in and obtaining hard data to analyse. The researcher strives for objectivity, detachment and neutrality. In short, qualitative approaches celebrate researcher subjectivity and quantitative ones see subjectivity as ‘bias’ and claim to eliminate it.

Unsurprisingly, these different aims and methods generate different kinds of findings. Qualitative research findings tend to be complex, rich, messy and ambiguous. They are usually expressed through words or through creative arts. Quantitative research favours specific, numerated outcomes with emphasis on scientific rigour (which can sometimes prove reductionist) (Finlay, 2006a).

To help illustrate the special qualities of qualitative research, consider the research of Qualls (1998) into the phenomenon of ‘being with suffering’. Nine individuals who had travelled to Eastern Europe to work as volunteers with children in a Romanian orphanage wrote descriptions of their own internal worlds. This was followed by a ‘walk-through interview’ where they were able work through their accounts with the researcher. On analysing the data phenomenologically, the researcher found that the experience of seeing children being inhumanely treated had drained the participants’ personal reserves and challenged their sense of the world and their faith in God. The participants experienced powerful and ambivalent emotions, including simultaneous feelings of love, fear and disgust. Strong supportive bonds with colleagues and a sense of community helped them cope, both during the experience and for years afterwards. This research revealed with clarity and poignancy the struggles and long-term trauma of volunteers in challenging situations. Finding that volunteers required debriefing and long-term support also brought clear policy implications.
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The research undertaken by Gilbert (2006) into the impact of the death of a child on social services staff reveals the ability of qualitative research to tap into powerful emotions. As Gilbert recalls the experience:

I was aware of carrying the feelings of shame, that we should not be talking about C’s death and that in raising the issue I was breaking a taboo… co-researchers may not have been aware of its presence, projecting it outwards so I carried the feelings for them. (2006, p. 6)

By drawing on her subjectivity, Gilbert was able to offer valuable ‘evidence’ to better inform practice and policy regarding the staff support.

To explore other relevant studies see the lists on these useful websites:

Choosing Phenomenology as the Qualitative Method of Choice

I hope these examples have reinforced your inclination to consider the qualitative research route. If you have chosen to read this book, you are probably interested in qualitative research already. But what has phenomenology to do with all this? What exactly does it involve, and what does it offer therapists?

The aim of phenomenology is to describe the lived world of everyday experience. Lived experience can be general, such as what being a therapist is like, or else specific, such as being pregnant, dying of cancer, or having a sense of ‘losing one’s footing’ after a trauma. Phenomenological research into individual experiences gives insight into, and understanding of, the human condition. Sometimes it languages things we already know tacitly but have not articulated in depth. At other times quite surprising insights reveal themselves. Phenomenology also deepens our understanding of therapy practice and processes helping us in both our personal and professional development.

Phenomenological research is potentially transformative for both researcher and participant. It offers individuals the opportunity to be witnessed in their experience and allows them to ‘give voice’ to what they are going through. It also open new possibilities for both researcher and researched to make sense of the experience in focus.

In order to demonstrate the special value of phenomenology, I offer an extended quotation from a published study – see Example 1.1. I conducted this research collaboratively with my co-researcher, Pat, to explore her lived experience of her rehabilitation following a cochlear implant. Drawing on data from participant observation, interview and email correspondence over the course of several months, the resulting analysis focused on Pat’s dramatically evolving sensory experience as she learned what sound is and how to hear it.
Example 1.1 A phenomenological study of a changing lifeworld following a cochlear implant

All her energy was poured into coping with the hyper-noise. As Pat put it, “Everything is so noisy! Putting on a coat, trousers, writing on paper. It is so noisy! Sometimes I can’t bear it”.

On good days she relished her explorations of the new world unfolding before her . . . She felt a thrill each time she was able to distinguish a sound and hear it for the first time in 50 years . . .

On bad days, the surreal quality of all these strange crackling sensations in her head, together with her altered perceptions, made her feel “distracted” and “confused, out of control”. It was all so big and overwhelming. With her previous habitual way of being-in-the-world now under constant challenge, her self-confidence took a battering. She struggled to put her deafness in context, experiencing her existence as what she called a “messy limbo”:

“…How many mistakes have I made in my work and interactions that are based in the wrong interpretation of information? I cringe when I think about it . . .”

As Pat learned to map an expanding range of sounds, she also had to confront the fact that her relationships with people were changing. People somehow felt different, but Pat recognised that she was in fact the one who was changing . . . “Everything has been affected”, Pat said, “…my body, my thinking” . . . Pat found herself wanting to withdraw from social contact, to hide from the gaze of others. She craved solace from the tensions of her deafness which continue to be revealed to her in her disrupted interactions . . .

“I don’t want to face deafness, disability, implants anymore. I don’t like deafness as other people see it . . . I cannot follow things like others do even with the implant.”

. . . The full extent of her profound level of deafness, which she felt she had kept hidden [from her self and others], is now uncovered. She feels that she’s been caught out and left unprotected in the eyes of the public. She feels this shame both in relation to her present disability and to what she now understands as her past deep-going hearing disablement . . .

She is struggling to accept herself (both her hearing self and her deaf self) while simultaneously seeking to hide from herself. (This extract has been reproduced from Finlay, L. and Molano-Fisher, P. (2008) ‘Transforming’ self and world: A phenomenological study of a changing lifeworld following a cochlear implant. Medicine, Health Care and Philosophy, 11, 255–267, with the kind permission of Springer Publications.)
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This research had a major impact on both Pat and myself. For Pat, the process of being witnessed was a powerful and beneficial experience. She valued the opportunity to talk through, and make sense of, the surgery and rehabilitation she felt had derailed her life for a time. On several occasions we recognized a ‘therapeutic’ element to our research – an unlooked for outcome. For my part, I gained from a deepening friendship with Pat and a new perception of the world.

On a more professional level, the research had an influential ‘spreading the word’ effect. People considering the option of cochlear surgery have expressed their gratitude to us and the research has affirmed their experience. Doctors and audiologists from different parts of the world have been in touch to thank us for providing a glimpse into their patients’ experience. In one case, a somewhat surprised doctor unfamiliar with qualitative research told us ‘I have found this very illuminating and I will now give this information to my patients considering the surgery.’ Could there be a better validation of the use of qualitative, phenomenological methods?

Reflections

In this chapter I have suggested that qualitative research in general, and phenomenological approaches specifically, offer a bridge across the gulf that separates research from clinical practice within the field of therapy. In addition, I would also argue for small-scale, ‘practitioner research’ (McLeod, 1999) and practice-based evidence to study the value, processes and challenges of therapy. While such practitioner research does not rule out the use of quantitative approaches, I am a strong advocate of qualitative research that explores what health or illness means to individuals and the ways in which they experience therapy. Qualitative research also enables us to hear about practitioners’ own views, theories, approaches to, and intuitive hunches about practice allowing us to draw on their experience.

As I see it, phenomenology has a special role in all of this. I want to do and hear about research that teaches me something new and, ideally, moves me in some way. I want research with the potential to contribute something to my practice, to help me to better understand the therapeutic process and my clients’ needs. I seek research that enables them to make sense of their own experiences and have this witnessed. I also want to spread the word to others. All this, I argue, can be made possible through recourse to phenomenology, with its enriching and transformative possibilities.

For me, phenomenology has become more than a research methodology. It is a way of being.
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Between 1977 and 1991, I practised as an occupational therapist (and/or was in the therapeutic field) and then returned to clinical practice in 2008. I spent the intervening years studying phenomenology, getting my PhD and then retraining as an integrative psychotherapist. As I began seeing clients again, I was curious about how ‘rusty’ my skills would be. Somewhat to my surprise, I realized that I had become a vastly better therapist, more aware of myself, more ‘present’ with my clients, and far better attuned to their experience. Becoming a phenomenologist has transformed my being and doing. My capacity to be-with an Other has grown. I can sustain an approach to the Other that is open, respectful, non-instrumental and relationally oriented. I can dwell with them as they seek to describe their journey in all its richness and complexity.

Phenomenology has given me these gifts. She is a generous friend. You, too, will be richly rewarded if you come with me and cross the bridge.

Notes

i Some of the material in this chapter has been drawn from Chapter 4 of Finlay, L. and Evans, K. (2009) Relational-centred Research for Psychotherapists: Exploring Meanings and Experience, and has been reproduced here with kind permission of the publisher, Wiley-Blackwell.

ii A key politically orientated question to ask about any research is ‘In who’s interests is this?’ There is a danger that therapy knowledge as published in books/research becomes ever more dominated by academic and policy-driven (and ideologically driven) research. This can only open up the divide between practice and research even more. It also means that practitioners at the coalface who are less engaged in the research world may be silenced, marginalized and undervalued (McLeod, 1999).

iii The recognition that humans use narrative structure as a way to organize the events of their lives and to provide a scheme for their own self-identity is of importance for the practice of psychotherapy. . . . The telling of the story in itself is held to have therapeutic value, and sharing one’s own narrative with others helps bring cohesion to the support group (Polkinghorne, 1988, p. 178).

iv I prefer the concept of practice-based evidence instead of ‘evidence-based practice’. This approach enables relatively small-scale research in natural, everyday clinical settings. It places staff and service users’ experiences of therapy at the core of research (Finlay & Evans, 2009; Mellor-Clark & Barkham, 2003). Practice-based evidence can draw on both quantitative and qualitative research approaches. In practice-based research, clinicians are usually the main researchers (perhaps in collaboration with academics) and the research is usually integrated within a therapy programme (or the research is, itself, therapeutic). In such research, practitioners might offer detailed descriptions of some aspect of their clinical case work, perhaps including descriptions of the context and the work with patients/clients. Clinical or narrative case studies and/or studies that audit particular facets of practice are typical examples of practice-based evidence.

v Akihiro Yoshida (2010) offers a detailed explication of the implications of ‘why’ versus ‘what’ questions in a teaching context and suggests that both are needed in collaboration.
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‘Why questions’ produce more focused patterned answers providing explanation while ‘what questions’ invite more freeing creative reflections towards understanding.

v This extract has been reproduced from Finlay and Molano-Fisher (2008), ‘Transforming’ self and world: a phenomenological study of a changing lifeworld following a cochlear implant, in Medicine, Health Care and Philosophy, 11, 255–267, with kind permission of Springer Publications.

v Phenomenology has also impacted on my way of being-in-the-world more generally. I think and act phenomenologically: I use my bodily intuitions more readily and I have a greater awareness of the existential issues calling me. I find that when I go to a new place now, I will ‘feel myself into’ that space. Even the decisions taken in the design of my house were assisted by taking a phenomenological approach!