Application of Descriptive Phenomenological Research Method
to the Field of Clinical Research

Barbro M. Giorgi, Ph.D.
Saybrook University
United States

Abstract

The literature on the psychotherapeutic practices reveals a high level of discord. On one hand there is a clamor for evidence-based research and on the other hand there are many serious criticisms about the nature of empirical research on the therapeutic practices. On one side there are the logical rules for conducting allegedly sound research and on the other hand there are the experiences of therapeutic practitioners which seem to be at odds with the accepted rules. It is suggested that this chasm can be bridged by phenomenological research strategies that are experientially congruent and based upon the discovery of lived meanings derived from the concrete descriptions of the participants, whether therapists or clients.

As I embarked on my studies in psychology, I was frustrated by my experience which could be simplistically summarized by "but it’s not like that". All the theories I read in the textbooks held together beautifully as long as they remained on the page but the minute I tried to take them into "life" and tried to use them in order to understand myself or to understand others around me and our relationship to one another, the beautiful logic of the theory would collapse to one degree or another with me saying to myself "but it doesn’t work that way".

This frustration continued all through graduate school and, I think culminated in the literature review for my dissertation. From the very beginning of my education I experienced a gap between what I was being taught about psychology, and life as I experienced it. When I started my literature review about the therapeutic process I then also came face to face with the gap between clinical practice "the way it really works", and the research results that are supposed to inform this clinical practice.

There was an overwhelming amount of research on the topic but almost every article I read complained about the general lack of relevance of research findings to clinical praxis. Some complaints concerned the lack of ecological validity. Research is being conducted under circumstances that are too different from the way therapy is being practiced, dealing with issues in ways that are too simplistic and approaching clients in reductionistic ways. Throughout the literature there was a sense of crisis. First, a sense that research is not sufficiently relevant to
practitioners for them to even read the literature and secondly, a frustration over the lack of influence research was having on clinical training and the education of psychologists and, thirdly, a sense of urgency to show some clear and positive results in order to justify therapy, an urgency fueled by new economic and political pressures from managed care and third party payers. The literature was full of calls for new and different approaches to doing clinical research in order to overcome these issues. Some called for small variations, tweaking our methods a little and others were calling for a fundamental and radical paradigm shift.

The objections contained in the literature, and their sources, are summarized in Tables 1 and 2. Table 1 lists the types of objections being made about clinical research strategies, and Table 2 specifies the type of complaints being voiced concerning the lack of relevance of therapeutic research for therapeutic practice in general. I shall not dwell on these objections because most experienced clinicians are well aware of them, and besides, I want to concentrate on a key positive aspect that the phenomenological approach can bring to these issues. The key inference to be drawn from these two tables is that research into the therapeutic process is problematic, and because of this problematic status, this subfield of psychology should be open to novel strategies of research.

Table 1

The types of objections made about psychotherapeutic research over the last three decades by therapists/clinicians who conduct the research and their sources. Each source cited has at least one such objection, many have several, and a few contain them all.

<table>
<thead>
<tr>
<th>Objections Concerning Strategies</th>
<th>Sources</th>
</tr>
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</table>
Table 2
The types of objections made about psychotherapeutic research over the last three decades by therapists/clinicians who conduct the research and their sources. Each source cited has at least one such objection, many have several, and a few contain them all.

<table>
<thead>
<tr>
<th>Objections Concerning Clinical Relevance</th>
<th>Sources</th>
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<tbody>
<tr>
<td>Research conditions and practical clinical settings are at odds</td>
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<tr>
<td>There are tensions in scientific-practitioner model</td>
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<tr>
<td>Clinical research and clinical training are at odds</td>
<td></td>
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<tr>
<td>There is mismatch between level of conceptualization of phenomena and level of typical measurement</td>
<td></td>
</tr>
<tr>
<td>Decontextualized isolated variable studies are not ecologically related to clinical settings</td>
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My own frustration increased as I reviewed more and more of the traditional literature. Not only were there no answers to my own clinical questions, but it became quite clear that we do not really know what happens to our clients in therapy or how come therapy works. I had to conclude that the state of affairs of clinical research is indeed problematic. Research results show, without a doubt, that therapy does work, but, there are no significant differences to be found either in terms of schools of thought or in terms of implemented tools or techniques. Much research has been conducted, but no theory or type of practice can be shown to be better than any other. And, while there is no discernible difference between different theories or techniques, there is, moreover, no difference between professionals, paraprofessionals or lay persons nor are there significant differences related to level of experience among professionals. In other words, research shows that therapy works but it makes no significant difference what theory or technique you use nor how much experience you have. This is a problem both from a research perspective as well as from the perspective of training and education.

As I proceeded in my review it also became increasingly difficult to arrive at some kind of understanding of what the various aspects of therapy are in traditional terms; i.e., what are the variables? The literature is full of arguments for various aspects of therapy for its success. The list is long and contains concepts such as "being heard", "safety", "correcting erroneous cognitions", "corrective emotional experiences", "cathartic experiences", "dealing with unfinished business", plus many other lists of critical factors. A more complete list of these factors is presented in Table 3.
Table 3

Summary of factors designated as helpful in psychotherapeutic research.
(Table derived on the basis of data from Mahrer and Nadler, 1986).

<table>
<thead>
<tr>
<th>Criteria Used To Establish Good Moments</th>
<th>Helpful good moments</th>
</tr>
</thead>
</table>
| **Outcome Criteria**                   | -Voice quality was active, vivid and rich, energetic and expressive.  
-Client involvement and active engagement.  
-Willingness to communicate.  
-Commitment to change.  
-Trust in therapist.  
-Recognition of one's own responsibility, owning feelings and behaviors.  
-Client who engage in warm accepting dialogue.  
-Support-seeking relationship with their therapist. |
| **Normal Ways of Being and Behaving**  | -Mature behavior.  
-Reduction of defensive behavior.  
-Focusing on immediate experience.  
-Higher levels of cooperativeness; but also some disagreement and disapproval.  
-Emotional expression of feelings.  
-Depth of personal self-exploration.  
-Shift in self-concept. |
| **Theories of Therapeutic Practice**   | -Free and realistic expression of basic impulses.  
-Heightened awareness of interpersonal consequences.  
-Heightened positive attitude toward self and others.  
-Search for felt meaning and inner understanding.  
-Heightened awareness of higher order personal relative to opening up of life options.  
-Open and direct expression of feeling and emotions.  
-Engagement in internal encounters with deeper personality processes.  
-Experiential sampling of concrete new ways of being and behaving.  
-Cooperative attitudes with therapist  
-Hard work on problems.  
-Achieving emotional insight.  
-Being in a state of emotional arousal and ready to apprehend new ways of seeing selves and others.  
-Accessing cognitions, feelings and impulses previously unavailable.  
-Sense of completion, i.e. feeling that something had shifted and that a problem ceased to exist. |
Upon review, it can be seen that much of the literature emphasized a few particular aspects and suggested that this or that aspect was the most critical one. Some researchers indicated that the therapeutic relationship is the cornerstone of therapy while others would downplay the significance of the individual therapist and suggest that specific techniques account for success. Then, of course, there is the issue of *what is* successful therapy. Research can be broadly divided into process versus outcome research and this is linked to the issue of what constitutes successful therapy. A positive outcome such as a reduction of symptoms or symptom relief is one possibility, and so is increased functioning, increased insight and self awareness. More maturity and personal growth or a sense of deepened meaning of life and so on, are other possibilities. There is by no means any consensus as to what a positive result actually means or a consensus as to what should be examined. It seems that the philosophical and theoretical perspective of the researcher determines how and what is to be researched as opposed to a preexisting body of research findings or knowledge upon which to build further understanding. Some research emphasizes learning or modeling, intellectual insight, cognitive clarification and correction while others emphasize a human encounter in a "here and now" context or "in the moment" experience and still others take a spiritual approach and/or an embodied approach borrowing much from Eastern philosophy and its practices. Should the issue be symptoms, diagnoses and subsequent interventions, as in the medical model, or a more humanistic approach with a foundation in existential philosophy, or a biological, neurological perspective looking for genetic predispositions and biochemical solutions?

Yet another issue of how to approach clinical research is in terms of what time span to include. In the studies found in the literature the researchers have chosen a specific time period to examine such as a certain number of sessions, critical parts of single sessions, some of those decisions based on a numeric amount such as number of words as a cut-off point or number of minutes within a session, while others are based on content in the session such as emotional intensity, nature of the dialog between client and therapist and so on. Some studies take a somewhat longitudinal approach while others look at critical instances.
As a result of the literature review I felt more confused than ever and I was glad to have a phenomenological method as a research method at my disposal for a number of reasons and in a number of ways. [For details about the method, see Giorgi and Giorgi, 2003a; 2003b.] I will not be able to give full justice to the method here but I will highlight what I found to be some of the most important benefits of the very approach of the method in my study (von Knorring-Giorgi, 1998). First, let me describe briefly the data collection process and how this is relevant to the previous discussion. Phenomenology deals with concrete descriptions of experiences that participants themselves have lived through or experienced. This is critical because it saves the participants from having to know or understand why or how something works. In my study, I asked the participants to simply describe as concretely as possible their experience of a successful and lasting change that occurred within the therapeutic context for them. This did not require them to actually understand it but simply to describe it the way they had experienced it. This also meant, perhaps even more importantly, that I, as the researcher, did not have to know what to look for. I did not have to make decisions about whether it should be a certain number of sessions, whether to look at the therapeutic relationship alone or include the clients’ lives outside of therapy or whether to include other significant people in the clients’ lives. In a phenomenological study the researcher does not have to nor should he or she make such decisions. The research participants make those decisions and inform you about the various aspects that are important to them and how they relate to the issue in meaningful ways. When a person goes about describing an experience or event to another, he or she will spontaneously give the listener all the necessary background information so that the experience can be understood in its context. Not only did this save me from having to design "the right kind of study" in terms of time frame and what and who to include, what questions to ask, but results also provided a much more integrated picture of the process than what I had found in the literature in general.

Interestingly enough, all participants started with childhood, not in great detail and not in terms of traumatic experiences but each participant found it necessary to describe their familial relations and how they had perceived themselves and the world entering into therapy in order for me to fully appreciate what the experience of change within therapy had meant to them. This was interesting in the sense that none of the current research on psychotherapy had incorporated this into their inquiries. And in the literature in general, when childhood experience is included in research it is often approached in terms of specific problems or trauma. In any case, in the clinical research I reviewed, childhood was almost completely excluded. This is, of course, quite natural. If the decision of what time frame to limit the study to is to be chosen by the researcher, it would seem to most researchers a daunting task to have to start at the very beginning and include everything in the participant's life that could be connected to a therapeutic change. Of course, there is certainly the awareness that humans are complex beings and that in every moment of our lives we also incorporate all of our past history and experience as well as all our future goals, hopes, fears and aspirations, but this cannot be easily accommodated in a research project and so it is usually set aside from the inquiry. Phenomenology, in contrast, can to some extent accommodate this aspect of humans. This is important from a phenomenological perspective because it espouses to be faithful to the phenomenon of inquiry such that if this is indeed "how human beings are" then they must be studied in such a manner. What makes this, at least to some degree, possible is that in a phenomenological study the researcher does not have to ask about everything in the participant's life that might be of importance, but rather the participant will
make the decisions about where to start and what to include based on his or her own experience and include what is important to him or her and exclude what is not. This has the additional benefit of allowing for individual differences. In other words, what is important to one participant may not be to the next and most importantly, the researcher does not have to know this in advance. Another aspect that is critical here is the fact that the description is not about how the participants understood their own experiences but simply a description of "what happened" from their perspective. This means that the participant does not need to have a psychological insight into the processes involved. This is an important aspect of doing phenomenological research because it capitalizes on the human phenomenon of people generally being very good at "living life" or at "doing things" while much weaker at being able to "know" what we do or understand ourselves. Thus, in a description of a concrete lived experience so much more is revealed than would be possible if an explanation or an understanding of the experience was required. It is through the analyses of this concrete data that an understanding of the psychological meanings emerges.

Another concrete benefit of the phenomenological approach was that a particular important aspect of idiosyncrasy was not lost in the study. I will take a small but illustrative example from the findings in my study to demonstrate this point. In the literature the issue of safety in the therapeutic relationship was a common theme. Safety was also shown to be important in my doctoral research. The difference between how safety was discussed in the literature and what emerged from my study has to do with idiosyncrasy. The literature found safety to be an important aspect and then proceeded to outline what safety is for a client and how to achieve it in therapy. This study, however showed that this is not necessarily the best approach to the idea of safety in therapy. Safety was equally important to each of the participants, but what safety was and how it was achieved differed drastically from one person to the next. What makes this critical is that, in effect, what made one person safe would actually have threatened another. The implication of this is that we cannot, as therapists, attempt to understand in a generic manner, what makes a client safe and then proceed to provide the client with that generic sense of safety. Instead we must listen to each individual client and discern what exactly makes them feel safe and from there attempt to provide a tailor-made safety for each client.

This became especially evident in looking at two of the participants, both women, and recognizing that one of them needed to be nurtured and met with gentleness and warmth to feel safe, while the other woman felt safe because the therapist was confrontational and allowed her to also be confrontational. What is critical here is the psychological meaning of nurturing and of confrontation that each woman experienced. The woman who needed warmth and compassion was very capable and strong while feeling generally unloved and therefore felt neither cared for nor safe. The other woman instead was treated by significant others with warmth but was not allowed to stand up for herself and acknowledge her own desires and opinions, especially if these were in any way confrontational. The fact that confrontation was allowed in therapy and that she was not rejected or punished for being confrontational made her feel safe. Thus, we cannot answer the question of safety with a prescription such as warmth and understanding or with being confrontational and straightforward, but must look at the meaning that it holds for each client at the most private and idiosyncratic level. A phenomenological study seeks to uncover the specific meanings of concrete lived experiences and in this case the psychological meanings that essentially describe the therapeutic process. The risk of ending up with a "one size fits all" model
that actually does not fit anybody all that well is therefore somewhat less of a risk in a phenomenological study than may be the case in general.

In more general terms the phenomenological method offers the possibility to address issues that are not easily addressed with traditional research methods; i.e., those phenomena that are both more subtle, more intangible and more complex. Phenomenology allows for research in areas where it may be impossible to know what the critical variables are in advance both in terms of the time period to examine and in terms of what aspects of the phenomenon to look at and what players or individuals or relationships to include, where it is (as it is in most human contexts) impossible to control for variables and isolate specific aspects from their lived context and still get ecologically valid results. Phenomenology is discovery-oriented rather than hypothesis-testing oriented and the researcher can therefore pose research questions where not many prior answers exist.

Perhaps the discovery aspect of phenomenological research should be emphasized more. The "hypothesis-testing" method is surely a tried and true method in science. It certainly works well where there is solid background knowledge and certain specifics have to be tested where true independence of variables exists. But a more open-ended, discovery oriented approach seems more adequate for phenomena that contain many individual differences and where genuine independence among the factors (variables) do not exist. In a "hypothesis-testing" method, one has to know, or presume to know, quite a bit before the role of a specific factor can be determined. The discovery approach does not assume specific a priori knowing. Rather, it more generally asks, "How is the phenomenon operating? What is going on that makes it work, when it does?" Such questions are far more important where interdependency among the so-called variables exist. The traditional experimental method assumes genuine independence of variables so that each variable can be modified without simultaneously affecting other variables. But that condition does not exist with experiential phenomena, where strong inter-dependency is the norm. As with all gestalts, if one modifies one factor, all of the others are spontaneously modified because of internal connections among them. Consequently, all experiential changes have to be understood holistically and, initially, idiosyncratically. In such an approach, the specific experiences of therapeutic change are directly discriminable because they are contextually understood. Generalizations have to be made relationally and contextually, not in terms of the effects of isolated variables.

An important part of the strength of this research approach as applied to clinical research is that results have ecological validity. What perhaps was most personally satisfying for me conducting this study was the response from other clinicians to the findings rather than meeting the skepticism so prevalent among clinicians vis-à-vis research my study has been greeted with enthusiasm from colleagues. I have also been pleased to find myself informed by the findings in my own clinical work and this is indeed the very reason for my passion for clinical research.

Finally, a concrete practical implication of my study was that the results indicated most of the same findings already in the literature, but more importantly, it also gave some indication of how the findings related to each other and the context in which therapeutic change occurs. The study was holistic, contextual and concrete, and yet generalizations were possible. To have conducted such a comprehensive study using traditional research methods would have been impossible given the scope of the study but because the participants gave a comprehensive picture of the event as it related to their entire life while also restricting themselves only to what...
was relevant, the phenomenological approach used in this study offered a more comprehensive picture than would, to some extent, otherwise have been possible.

**References**


