



# Qualitative methods in child and adolescent psychiatry: the time has come

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In this issue of *ECAP*, Lawrence et al. describe factors that influence families' participation in programs designed to alleviate their children's anxiety disorders. As part of a longitudinal project, children in the study had been diagnosed at a young age, resulting in a homogeneous sample. In this editorial we focus less on the study itself than on the approach used by its authors. As is the norm in the qualitative methods landscape, no *p* values are in sight. Such a rarity in these pages warrants using this contribution as a springboard for discussion.

As child and adolescent psychiatrists, we are by and large unfamiliar with the qualitative approach. When we are, the literature we read seldom comes from the journals in our field; most of us do not read qualitative works on a regular basis. A quick look at Pubmed shows that in 2000 there was a single published report under the keywords ("child and adolescent psychiatry") AND ("qualitative research") OR ("qualitative study"); in 2001 and 2002 there were none. It is only since 2015 that ten or more articles have been published each year, with a steady increase since then, up to a modest 43 by 2021. Why has our discipline been disconnected from qualitative approaches for so long, and why is it slowly starting to change only now?

Qualitative investigators favor words over numbers, in long-standing contrast to quantitative scientists who gravitate in the opposite direction. Among philosophers, Plato wanted to engrave at the entrance to his academy, "Let no

ignorant of geometry enter here". In the eighteenth century, Pascal contrasted in his *Pensées* "the spirit of finesse" with "the spirit of geometry": on one side, the understanding of the world in its complexity and shades; on the other, the clear-cut representation of reality by abstract and formal concepts reducible through mathematics. By the nineteenth century, scientific disciplines continued to experience tensions of the kind: Auguste Comte, at the origins of the positivist perspective, suggested that the sciences should be conceived as the study of an external and objective reality made out of matter. Tangible matter can in turn be modified by forces subject to universal laws, such as those of Newtonian physics. In turn, Wilhelm Dilthey argued that Comte's position was not relevant when the object of research was human beings. More precisely, he considered that nature can be *explained*, whereas mind can only be *understood*: "we *explain* through purely intellectual processes, but we *understand* through the cooperation of all the powers of the mind activated by apprehension" [1]. Formal and quantitative approaches are relevant to the natural sciences, but human complexity cannot be fully grasped through them.

Qualitative research is based on data that cannot be distilled into the traditional files in which patients are distilled into rows and variables related to them into columns. Instead, its usual sources of information include in-depth interviews, focus groups, video tapes, written materials: words, and the non-verbal cues related to them (e.g., body gesture, silences). Data analysis does not rely on statistics but on a "hermeneutic circle" in which meaning has to be contextualized within cultural, historical, and literary givens, where the whole can only be understood through its parts, and its parts through the whole [2]. In practice, one or more investigators code meticulously all pieces of the materials collected. Through successive iterations, sometimes with the help of software, these codes are grouped into categories that help generate consensual interpretations within the group of researchers. There are many qualitative analytic strategies [3]. Among the most relevant to

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CAP are: (1) Grounded Theory (GT), which addresses the context in which social actors interact and seeks to develop an overarching theory of the phenomena studied; (2) Interpretative Phenomenological Analysis (IPA), which aims to understand the subjective experience of people; and (3) Thematic Analysis (TA), focused on the interpretation of patterns of meanings. As sentient beings, we are part of the reality we seek to describe. In that tradition, rather than considering our own views as bias, we can fruitfully incorporate them as part of an exercise in reflexivity. At a practical level, the objective/positivist tradition can be mapped on to quantitative methods; the interpretivist/constructivist, to qualitative methods; and the two synergized when combined into mixed methods designs [4].

As a medical discipline, psychiatry is particularly sensitive to the duality between words and numbers, between qualities and quantities, between "soft" and "hard" approaches. From the time of Pinel to the work of Freud and beyond, psychiatric investigators have relied on patients' narratives. Talking with patients has been central to psychotherapeutic interventions. Qualitative approaches and their optimal fit to deal with spontaneous offerings and unstructured materials—and to grasp patients' intimate experiences—should thus have an important place in psychiatric research. The increased complexity of child and adolescent psychiatry (CAP) makes the approach all the more relevant: children cannot be considered outside their familial and cultural contexts and developmental trajectories. To paraphrase Winnicott, there is no such thing as a baby, only a "nursing couple". However, and all too curiously, qualitative research has been marginalized at best, dismissed at worst. Why is this the case, and why might we be taking a turn?

As the sociologist Bruno Latour explains, scientists tend to advance their careers by convincing others that their theories or findings are best. When a controversy arises between two teams of scientists, rivals debate over technical considerations. The metaphor of Latour is the escalation of a fight: each party entrenches further in an attempt to convince the "opposing" party that they alone are right. As a result—and not as a cause—scientific publications become increasingly technical. The precision of statistics, numbers, and *p* values convey scientific authority. Figures and graphs present the readers with what they are asked to believe. In the words of Latour, "the question is no longer to believe, it is to see" [5].

We posit that the hegemony of quantitative methods in CAP reflects our efforts to be recognized as a scientific discipline. However, part of this fight is not for science, but against social stigma. Because of three inherent liabilities, CAP is under regular threat of being overlooked by society at large, and by medicine in particular. First, it focuses on children; second, it deals with mental health; and third, its history involves psychoanalysis. In its elision of qualitative

methods to prove its legitimacy, CAP not only ignores these sources of stigma but indeed internalizes them.

Regarding the first weakness, citizens under the age of 18 are an underrepresented minority subject to *childism*, the systematic prejudice against children [5]. Non-voting and not contributing to the workforce or to taxation, children are regularly skipped over, ignored, or even considered parasitic drains. If this view appears contrarian or does not ring true, consider the scant assignment of resources to prenatal care, affordable high-quality daycare, or early education. Despite overwhelming evidence for their return on investment when compared to later allocation of funds, young children's needs are given smaller financial support [6]. In a similar fashion, CAP as a subspecialty experiences childism-by proxy, regularly perpetuated by its parent field of general psychiatry and medicine more broadly.

Second, our discipline is liable to a spurious syllogism: (1) CAP is a medical specialty; (2) medicine treats diseases; (3) diseases are operationalized in terms of organ dysfunction; ergo it should logically follow that (4) CAP involves brain dysfunction. This may explain why the neuroscientific paradigm has been adopted by most CAP investigators since the latter part of the twentieth century—in the form of brain imaging, genetics, psychopharmacology, cognitive neurosciences, epidemiology, or randomized controlled trials. Nevertheless, the mind resists facile explanation through these scientific means, yet CAP has fallen prey to the belief in a hierarchy of medical disciplines, with those related to single organs the most valued. Paradoxically, the same "organ-based" medical specialties publish more qualitative research in their journals than CAP does in its own.

Finally, CAP is burdened by the legacy of psychoanalysis and its worst excesses: its insularity, its imperviousness to scientific inquiry, its preciousness, its aloofness from social justice. We acknowledge that our own pendulums swung too far away from dynamic thinking; we suspect the same happened to our field. We consider that despite sharing similar roots with philosophy, sociology, or anthropology in thinking deeply about words and their meaning, as psychiatrists we have snubbed interpretivist ways of knowing in our effort to prove ourselves biological folk, as "real" scientists, unlike those caricatured analysts of yore. Through such misguided ourselves along the way. We failed to identify how the diminution of CAP is rooted in larger societal and medical mores.

Other misunderstandings have contributed to the limited diffusion of qualitative research in psychiatry. Most scientific findings are disseminated as articles or conference proceedings accepted or rejected after peer review. To guarantee the reliability of results presented to the community, editors and reviewers have to be experts in CAP with a solid methodological background (typically "hard"). This in turn presents a challenge to assess qualitative studies:

reviewers may be caught off guard by works belonging to such a different epistemology, an alternative way of knowing. In turn, qualitative researchers are often frustrated when reading comments about their work, the wrong lens through which to assess qualitative findings: “How did you justify your (small) sample size?”, “Where is your control group?”, “How can you generalize your results and determine they are reproducible?”, or “What is the level of evidence of your findings?”.

But a time for change has come.

Little by little, researchers have realized the unique potential of qualitative approaches in CAP and decided to embark on the adventure. It took time to be trained and to learn how to formulate a research question within such a different context. But qualitative studies were done, papers submitted, and the editorial boards of *ECAP (European Child and Adolescent Psychiatry)*, *CAPMH (Child and Adolescent Psychiatry and Mental Health)* and *CAMH (Child and Adolescent Mental Health)*, among others, were intrigued. These manuscripts offered the possibility of better understanding subtle phenomenological elements and the individuality of patients, families, and even social systems.

One of us tried to address the shortcomings of the entirely numerical by co-editing two series soliciting qualitative and mixed methods submissions: one focused on the interface between CAP and the COVID-19 pandemic [7], another on that between psychiatry and medical education [8]. Qualitative research is sometimes the only available method to study discrete yet impactful phenomena, as exemplified by recent work from our group and others: patient and family perspectives about ADHD, anhedonia, or selective mutism [9–11]; stigma experienced by underrepresented minorities and their obstacles accessing mental health services [12, 13]; barriers to science implementation in CAP [14–16]; the individual experience of child and adolescent mental health providers during the early days of the pandemic [17, 18], or the experiences of medical students during their clerkship in adolescent psychiatry [19].

Bolstering this uptake in the qualitative approach, an influential part of the scientific community has expressed skepticism about the relevance of positivist works alone. Thomas Insel, former director of the National Institute of Mental Health, concedes in a recent book that “Nothing my colleagues and I were doing addressed the ever-increasing urgency or magnitude of the suffering millions of Americans were living through—and dying from.” Allen Frances, a leading American psychiatrist, considers “[t]he end result of these last 30 years an exciting intellectual adventure, one of the more fascinating pieces of science in our lifetimes, but [one that] has not helped a single patient”. These provocative statements are likely to be extreme but converge in promoting innovation that is closer to the granularity of patients’ lives, to their unique perspectives and needs.

Today’s geopolitical situation at the borders of Europe is a reminder of the destructive effects of a powerful ideology fighting over bluster while becoming increasingly disconnected from the realities on the ground.

We make a final case against the quantitative hegemony so evident in our field and its scholarship: we must reckon that numbers can say only so much, and that we need to better listen and better represent the voices of those under our care, especially of those who have been unheard or disenfranchised for far too long. We believe that less quantity and more quality can help us meet those aspirations.

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