



Practice Qualitative Research

Why use theories in qualitative research?

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Theories such as interactionism, phenomenology, and critical theory can be used to help design a research question, guide the selection of relevant data, interpret the data, and propose explanations of causes or influences

Previous articles in this series have addressed several methodologies used in qualitative research. Qualitative researchers also rely heavily on theories drawn from the social sciences and humanities to guide their research process and illuminate their findings. This article discusses the role and use of three theoretical approaches commonly used by qualitative researchers in health domains: interactionism, phenomenology, and critical theory. It also explains why such theories are important for clinicians, for health policy, and for patient care.

Why is theory useful?

Theories provide complex and comprehensive conceptual understandings of things that cannot be pinned down: how societies work, how organisations operate, why people interact in certain ways. Theories give researchers different “lenses” through which to look at complicated problems and social issues, focusing their attention on different aspects of the data and providing a framework within which to conduct their analysis.

Just as there is no one way to understand why, for instance, a culture has formed in a certain way, many lenses can be applied to a problem, each focusing on a different aspect of it. For example, to study doctor-nurse interactions on medical wards, various theories can provide insights into different aspects of hospital and ward cultures. Box 1 indicates how each of the theories discussed in this paper could be used to highlight different facets of this research problem.

Box 1 How different theories help illuminate the culture of doctor-nurse interactions on a medical ward

Phenomenology

A researcher using phenomenology would approach the study of doctor-nurse interprofessional interactions by exploring how individual doctors and nurses made sense of their ward-based interprofessional experiences. Such a study would aim to elicit, through interviews, the meanings each individual attached to their interactions and the classifications they employed to make sense of their working lives within this context. Data would be analysed inductively, focusing on allowing meanings to emerge from the interviews. Specifically, this process would entail examining statements from the interviews and clustering them to form common themes linked to understanding the meanings that doctors and nurses each individually attached to their interactions.

Interactionism

Interactionist theory would be used to explore how the interprofessional relations within a medical ward context were created and modified during the daily interactions of doctors and nurses. Researchers in such a study would observe how doctors and nurses interacted (both verbally and non-verbally) in their shared clinical work; they would also interview both groups to understand the meanings they attached to their differing interprofessional interactions. Data would be analysed inductively by examining observational field notes and interviews to identify and explore the different elements which contributed to the nature of doctor-nurse interactions within a particular context. For example, researchers might examine differences between formal interactions (in front of patients) and informal interactions (in more private hospital settings).

Critical theory

A researcher employing critical theory would approach a study of doctor-nurse interactions by asking how power is related to characteristics of individuals or groups (for example, gender, race, culture). For example, critical scholars such as Anne Witz have shown that professions form hierarchies in which the dominant ones are predominately male (doctors), the first subordinate profession is largely female (nurses) and the most subordinate are often members of ethnic minorities (nursing assistants).¹⁴ Data analysis would be informed by the specific critical theoretical lens selected by the researcher. For example, data could be filtered through a feminist lens to help understand how patriarchy operates through doctor-nurse interactions within medical ward settings.

What are examples of theories used by qualitative researchers?

Phenomenology

This theory was originally developed by Edmund Husserl to explain how individuals give meanings to social phenomena in their everyday lives. The role of phenomenology was therefore to explore “the essence of

consciousness as experienced from the first-person point of view.”¹ Studies that draw upon this theoretical perspective concentrate on exploring how individuals make sense of the world in terms of the meanings and classifications they employ. As such, phenomenology aims to provide accounts that offer an insight into the subjective “lived” experience of individuals.² Given the emphasis, phenomenological studies do not attempt to generate wider explanations; rather their focus is on providing research accounts for individuals in a specific setting.

In general, studies that draw upon a phenomenological approach gather data in the form of in-depth semistructured or unstructured interviews and personal documents such as diaries. For example, Porter and colleagues used in-depth individual interviews to understand the meanings people living in residential homes held about their caregivers,³ whereas Mitchell gathered the meanings of being a senior from narrative stories written by older people about their personal experiences in later life.⁴ Theories that privilege understanding of human experience in terms of individual consciousness, such as phenomenology, share links to the work of the German philosopher Georg Wilhelm Friedrich Hegel and French existentialists such as Jean-Paul Sartre. However, phenomenology, as a result of its specific, empirical focus on the individual experience, is an example of a micro level theory within this philosophical orientation.

Interactionism

In contrast to the phenomenological focus on understanding individual perceptions, interactionism concentrates on exploring collective (group or team) behaviours and perceptions. Originally developed by George Mead, this approach aimed to provide an understanding of individuals’ interactions by examining the symbols, especially the language, they use in their daily encounters. In particular, interactionism is an approach that aims to elicit an understanding of how meaning is created and modified by individuals through their social actions, interactions, and reactions. Herbert Blumer outlined interactionism’s three guiding assumptions: that human beings act towards things on the basis of the meanings that these things have for them; that the meaning of such things is derived from, and arises out of, social interaction with one’s fellows; that these meanings are handled in, and modified through, an interpretative process used by the person in dealing with the things he or she encounters.⁵

Given the emphasis on understanding the processes of social interactions, interactionist research studies often draw on methods of data collection such as participant observation and interviews to capture these elements of social action. For example, Goffman found that individuals’ interactions are largely dependent on whether they are interacting in a “front stage” (a hospital ward, for example) or a “backstage” (private office, for example) setting.⁶ More recent research on the socialisation of medical students has indicated the significance of front and backstage performances in their socialisation.⁷

Several theories conceptualise reality as a social or collective construction, and these have roots in the work of European writers such as Émile Durkheim and Lev Vygotsky and of Americans Peter Berger and Thomas Luckman. Interactionism attempts to generalise beyond the individual experience but retains a mid-range focus on local systems and contexts within this broader social constructivist school.

Critical theory

Critical theory is oriented towards critiquing and changing society as a whole.⁸ With roots in the work of Marx on production and capitalism, it was further developed at the Institute for Social Research of the University of Frankfurt in the 1930s. More recently, this tradition has been carried on by social scientists

such as Pierre Bourdieu and Michel Foucault.

Critical theorists study how the construction of knowledge and the organisation of power in society generally, and in institutions such as schools, hospitals, and governments specifically, can lead to the subjugation or oppression of particular individuals, groups, or perspectives. Critical theorists are concerned with equity and justice in relation to issues such as race, socioeconomic status, religion, and sexuality.⁹ For example, Battiste studied how Euro-American dominated health care, pharmaceutical research, and educational institutions marginalise indigenous knowledge, and how both endangered certain populations and marginalised important knowledge about health and the environment.¹⁰ Muzzin used critical theory in her study of how education of health professionals has come to reflect corporate interests, thereby reproducing gender and class inequity, as universities developed “academic capitalism.”¹¹

Critical theory is not tied to one specific methodology and can be applied at the micro (individual), macro (local systems and contexts), or macro (societal) level.

Aren't there a lot more theories?

The three theories we have discussed so far in this paper are examples of the possible theories a qualitative researcher might use. Box 2 provides some further examples of other theories that have been used in qualitative research studies in domains related to medicine.

Box 2 More examples of theories used in qualitative research

Professionalisation theory

Elliot Freidson developed his theory of professionalisation in response to previous explanations that had considered only the range of positive traits of professional groups.¹⁵ Freidson argued that occupational groups, such as medicine, had previously engaged in a process of professionalisation to secure exclusive ownership of specific areas of knowledge and expertise. In obtaining exclusivity, occupational groups secure autonomy of practice, which leads to economic rewards and enhanced status. To protect the gains obtained from professionalisation, occupations guard their areas of knowledge and expertise through strict regulation of entry and the maintenance of professional standards. More recently, this theory has been questioned because of the increasing influence of clinical management on medicine, which Haug argued had resulted in a “deprofessionalisation” process, whereby some of the professional gains described by Freidson have been undermined.¹⁶

Labelling theory

Originating in the sociology of deviance, labelling theory focuses on how society can negatively label a group whose behaviour is deemed as deviating from the norm. The theory was applied in a healthcare context by Scheff to help understand the nature of mental illness.¹⁷ Scheff argued that mental illness is essentially generated as a result of societal influence. To understand deviant actions, individuals often place the label “mental illness” on those who show such actions. Certain expectations are then placed on these individuals and, over time, they unconsciously change their behaviour to fulfil them (a notion termed self fulfilling

prophecy). Empirical work by Link et al has shown how influential labelling can be for mentally ill patients: once they are labelled as having this type of illness, people may withdraw from society.¹⁸

Negotiated order theory

This theory was developed by Strauss et al to advance thinking about the way social order is maintained in organisations.¹⁹ Previous explanations of social order within organisations tended to emphasise formal structures and rules and to neglect the influence of negotiations at the micro level. For Strauss and his colleagues, negotiation between individuals (through bargaining, compromising, and mediating) creates and shapes organisational rules and structures. Consequently, micro level negotiation contributes to the development and maintenance of the social order that exists within an organisation. This theory has been used in various organisational settings, including health care, where it indicated that informal negotiation was key in nurse-doctor decisions on patient care.²⁰

Following work by Merton, such theories can usefully be grouped into a taxonomy to guide novice researchers as to which theories are likely to be helpful in dealing with a particular research problem (table 1).¹² As shown in the table, grand or “macro” theories are non-specific and constructed from relatively abstract concepts. As a result of their wide ranging nature, these types of theories are difficult to operationalise and verify on an empirical basis. Mid-range theories consider specific phenomena and involve a small number of concepts relating to a restricted range of contexts. “Micro” or practice theories have the narrowest range of interest and are focused on specific phenomena and contexts. Box 3 addresses further frequently asked questions about theories in qualitative research.

Type of theory	Focus	Biomedical domain (positivist orientation)	Psychological domain (psychodynamic orientation)	Social domain (constructivist orientation)
Grand theory	Universal, societal level theories	Germ theory (Pasteur)	Psychodynamic theory—ego, defences, etc (Freud)	Social construction of reality (Berger and Luckman)
Mid-range theory	Local systems; recognition of cultural or contextual variations	Droplet theory of TB infection (Wells)	Five stage theory of grief (Kübler-Ross)	Social interactionism (Blumer)
Micro level theory	Individual level action, interaction but local context also key	Theory of personal respiratory protection (Kennelly)	Individual formulation of illness and loss—psychodynamic life narrative (Viederman)	Phenomenology (Husserl)

Types of theory, with examples from related domains

Box 3 Frequently asked questions

How is the term “theory” defined?

A theory is an organised, coherent, and systematic articulation of a set of issues that are communicated as a meaningful whole.

How are theories generated?

Theories are usually generated deductively, from an empirically informed act of creativity, then empirically verified. In this sense, theories result from an ongoing process of deduction and induction.

How can theories be used?

Theories are usually used to help design a research question, guide the selection of relevant data, interpret the data, and propose explanations of the underlying causes or influences of observed phenomena.

Can theories be used to predict research findings and generate hypotheses?

In general, theories in the natural sciences are used to generate predictions about the relation between two or more different variables in order to generate universal laws. In contrast, social scientists assume that social reality is too complex to consider variables in isolation in order to test their causal relationship. In addition, social scientists view universal laws as being unable to explain the complex interrelated functions of societies, thus making it impossible to draw on evidence for prediction. So, for social scientists, a theory is first and foremost a conceptual tool useful in making sense of a complex social reality.

How are theories and methodologies related?

Some theories and methodologies are historically related—that is, they both derive from the same discipline or school, and although they are sometimes used separately they are often taught and used together. The classic example of this is the link between interactionism (theory) and ethnography. Other theories (or families of theories) link well with multiple methodologies. For example, critical theories have been used to varying effect with almost every available methodology (both qualitative and quantitative).

Are these all the possible theories?

No—we have just scratched the surface. Theories have been developed and modified over several hundred years and have dialectically informed each other's changes over time. The theories we have mentioned in this paper are those that readers are likely to encounter in the health domain. Other important theories used often in the social sciences and humanities, but only occasionally in health related research, include (but are not limited to) marxism and its descendants, feminism, hermeneutics, and the post-modernist family of theories.

Box 4 Further reading

Crotty M. *Foundations of social research: meaning and perspective in the research process*. London: Sage, 1998.

Denzin NK, Lincoln YS, eds. *Handbook of qualitative research*. 2nd ed. Thousand Oaks, CA: Sage, 2000.

Layder D. *Understanding social theory*. London: Sage, 1994.

Ritzer G, Smart B, eds. *Handbook of social theory*. London: Sage, 2003.

Roberts B. *Micro social theory*. Basingstoke: Palgrave, 2006.

Scamber G, ed. *Sociological theory and medical sociology*. London: Tavistock, 1987.

Stones R, ed. *Key sociological thinkers*. Basingstoke: Macmillan, 1998.

Why is theory important to health policy and patient care?

Theories such as those described above are important to health policy and the delivery of patient care, as the insights they provoke enable research that provides practitioners with a broader understanding of the situations they face in their daily working lives. The use of theory makes it possible for researchers to understand, and to translate for policy makers and healthcare providers, the processes that occur beneath the visible surface and so to develop knowledge of underlying (generating) principles. Importantly, theory can help people move beyond individual insights gained from their professional lives to a situation where they can understand the wider significance and applicability of these phenomena. Good theory based research is immediate, insightful, and applicable in practice; in the words of Kurt Lewin, “there’s nothing so practical as a good theory.”¹³

Summary points

Different theories provide different lenses through which to analyse research problems

Various theories are currently used within health related research

Theories can be divided into macro (or grand) theories, mid-range theories, and micro (or practice) theories.

Theories can arise from, or be used within, different research domains (for example, biomedical domain, psychological domain, social domain)

The insights derived from theories are important for guiding health policy and informing the delivery of patient care

Notes

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Footnotes

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- This is the fifth in a series of six articles that aim to help readers to critically appraise the increasing number of qualitative research articles in clinical journals. The series editors are Ayelet Kuper and Scott Reeves.
- For a definition of general terms relating to qualitative research, see the first article in this series.
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References

1. Smith D. *Husserl*. London: Routledge, 2007.
2. Schutz A. *The phenomenology of the social world*. New York: Northwestern University Press, 1967.
3. Porter E, Ganong H, Drew N, Lanes T. A new typology of home-care helpers. *Gerontologist* 2004;**44**:750-9.
4. Mitchell G. The meaning of being a senior. *Nurs Sci Q* 1994;**7**:70-9.
5. Blumer H. *Symbolic interactionism: perspective and method*. Englewood Cliffs, NJ: Prentice-Hall, 1969.
6. Goffman E. *The presentation of self in everyday life*. London: Penguin, 1963.
7. Sinclair S. *Making doctors: an institutional apprenticeship*. Oxford: Berg, 1997.
8. Calhoun C. *Critical social theory: culture, history and the challenge of difference*. Oxford: Blackwell, 1995.
9. Kinchloe JL, McLaren P. Rethinking critical theory and qualitative research. In: Denzin NK, Lincoln YS, eds. *Handbook of qualitative research*. 2nd ed. Thousand Oaks, CA: Sage, 2000.
10. Battiste M. You can't be the global doctor if you're the colonial disease. In: Tripp P, Muzzin L, eds. *Teaching as activism: equity meets environmentalism*. Montreal and Kingston: McGill-Queen's University Press, 2005:121-133
11. Muzzin L. The brave new world of professional education. In: Tripp P, Muzzin L, eds. *Teaching as activism: equity meets environmentalism*. Montreal and Kingston: McGill-Queen's University Press, 2005:149-166
12. Merton R. *Social theory and social structure*. New York: Free Press, 1968.
13. Lewin K. *Field theory in social science: selected theoretical papers*. New York: Harper & Row, 1951.
14. Witz A. *Professions and patriarchy*. London: Macmillan, 1992.
15. Freidson E. *Profession of medicine: a study of the sociology of applied knowledge*. New York: Harper & Row, 1970.
16. Haug M. De-professionalisation: an alternative hypothesis for the future. *Sociol Rev Monograph* 1993;**20**:195-211.

17. Scheff T. *Being mentally ill: a sociological theory*. 3rd ed. New York: Transaction, 1999.
18. Link B, Phelan J. The labelling theory of mental disorder: The consequences of labelling. In: Horwitz A, Scheid T, eds. *A handbook for the study of mental health*. New York: Cambridge University Press, 1999:361-76.
19. Strauss A, Schatzman D, Ehrlich R, Bucher M, Sabshin C. The hospital and its negotiated order. In: Freidson E, ed. *The hospital in modern society*. New York: Free Press, 1963:147-69.
20. Svensson R. The interplay between doctors and nurses—a negotiated order perspective. *Sociol Health Illness* 1996;**18**:379-98.