

Measurement, meaning and the limits of research methods in mental health: a case for methodological pluralism

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Abstract

Purpose – *This paper explores the limits of current research methods in mental health. Quantitative methods are useful for diagnosis, measurement and treatment outcomes, but they do not fully capture patient experience, meaning and cultural context. The aim of this study is to highlight the importance of combining quantitative and qualitative approaches. A more balanced and practical approach may improve understanding of mental illness and support better clinical care and research.*

Design/methodology/approach – *This is a viewpoint paper based on existing literature from psychiatry and related fields. No new data were collected. The paper reviews and discusses key concepts such as measurement, diagnosis, patient experience and cultural factors. It compares quantitative and qualitative methods and explains how each contributes to clinical understanding. The discussion is based on published studies and theoretical work.*

Findings – *Quantitative methods are helpful for standardised assessment and treatment planning but may miss individual experience and context. Diagnostic categories and rating scales can shape how symptoms are understood. Qualitative approaches help to understand patient experience, meaning and cultural background. Both methods have strengths and limitations. A combined approach may give a more complete understanding of mental illness and improve clinical decision-making.*

Originality/value – *This paper adds value by highlighting the practical limits of relying only on quantitative methods in mental health research. It emphasises the need to include patient experience, meaning and cultural context in both research and clinical practice. The paper presents a clear argument for using both quantitative and qualitative approaches together, rather than treating them separately. This perspective is useful for clinicians and researchers, as it supports more holistic assessment, better understanding of patients and more informed clinical decision-making.*

Keywords *Psychiatric research, Qualitative methods, Clinical formulation, Diagnostic categories, Cultural psychiatry, Mixed methods, Meaning-making, Mixed method, Mental health, Psychiatry, Analysis*

Paper type *Viewpoint*

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Introduction

Quantitative methods have given psychiatry reliability, standardisation and predictive power (Beg, 2025), yet they remain limited in engaging fully with the domain of meaning through which psychological experiences are lived and communicated. This tension raises a fundamental question: Do prevailing methodological frameworks genuinely capture the complexity of mental life or do they, by their very structure, leave certain dimensions underrepresented? To raise this is not to dismiss quantitative approaches, but to recognise their *epistemic boundaries* and to consider more carefully the complementary role of qualitative inquiry.

This argument draws on longstanding discussions in the philosophy of psychiatry – on the interpretive nature of understanding, the effects of classification and the cultural

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embeddedness of distress. These concerns carry direct implications for clinical practice: for how psychiatrists formulate cases, communicate diagnoses and engage with patients whose explanatory models may differ from biomedical accounts. The viewpoint is addressed, therefore, not only to researchers but to clinicians as practitioners who encounter these epistemological questions not in the abstract, but in every consultation.

Limits and strengths of quantification

Through psychometrics, epidemiological research and randomised controlled trials, psychiatry has produced knowledge that is systematic, replicable and cumulative (Scognamiglio *et al.*, 2023). Diagnostic systems such as the ICD and DSM provide a shared clinical language enabling consistent communication, classification and intervention across settings.

Yet limitations are visible within this success. A score on a depression *scale* does not neutrally reflect distress; it represents it in a form shaped by prior assumptions and thresholds. In translating lived experience into measurable units, comparability and analytic utility are gained – but nuance, contradiction and contextual specificity are necessarily reduced. *Diagnostic categories* and psychometric constructs also influence what counts as legitimate suffering and which forms of distress become visible within clinical and institutional settings (Andrade, 2024). For clinicians, a patient's rating scale score should be read alongside – not instead of – their subjective account. The discrepancy between the two is itself clinically informative and should prompt further inquiry rather than being resolved in favour of the number.

The case for qualitative inquiry

Qualitative inquiry complements quantitative methods by addressing questions that measurement alone cannot reach. Where quantitative research asks *how much* or *how often*, qualitative research asks how experiences are lived, interpreted and shaped within everyday life. This distinction is not merely academic: many of the most clinically consequential questions in psychiatry – why patients disengage from treatment, how recovery is understood across cultural settings, what a diagnosis means to the person who receives it – are questions of meaning rather than magnitude.

Subjectivity is not a private inner domain; it is formed through language, culture and social interaction (Palinkas, 2014). Individuals draw on available narratives, diagnostic vocabularies and culturally situated meanings to make sense of their distress. Eliciting these accounts – through open clinical dialogue alongside structured instruments – is therefore a matter of direct clinical relevance.

Meaning-making: central, yet not beyond question

Individuals do not merely experience symptoms; they interpret them through *explanatory models* that may be biological, moral, spiritual, social or existential in nature (Zegarra-Parodi *et al.*, 2025). These interpretations shape help-seeking, therapeutic engagement and recovery trajectories and should be actively elicited in clinical encounters.

It would be a mistake, however, to treat meaning-making as inherently authentic or privileged. Meanings are often partial, unstable and shaped by language, memory, cultural narratives and unconscious processes (Dahlberg and Dahlberg, 2019). Some meanings actively reinforce distress or sustain stigma, shaping how patients relate to their diagnosis and whether they seek or persist with treatment. Qualitative research therefore does not simply amplify subjective accounts – it engages in their disciplined interpretation, recognising both their indispensability and their limits.

Diagnostic categories: tools that shape experience

Diagnostic categories are indispensable in clinical psychiatry, providing the scaffolding for communication, decision-making and evidence-based intervention (Jablensky, 2016). However, *categories* are best understood as pragmatic tools rather than definitive representations of reality – lived experience frequently exceeds their boundaries, presenting as fluid, ambiguous and contradictory. Comorbidity is the clinical rule rather than the exception and many patients present with subthreshold, mixed or evolving symptom profiles that resist neat categorical assignment.

Once a diagnostic label is applied, it can reorganise self-understanding, influence identity and structure future narratives. The *diagnostic encounter* is not a neutral act of classification; it is a consequential event in a patient's illness narrative that warrants careful communication and ongoing attention to how the label is received and integrated. Qualitative research is well placed to illuminate both what categories fail to capture and how they actively shape experience.

Culture and context

Mental health cannot be understood as culturally neutral. Expressions of distress, explanatory models and pathways to care are embedded within local systems of meaning (Osborne, 2026). In many contexts, psychological suffering is expressed through *bodily symptoms*, spiritual frameworks or familial negotiation. Standardised instruments developed within specific cultural settings may fail to capture this diversity (Mitra and Chatterjee, 2026) – a patient presenting with somatic complaints may be expressing distress in a culturally congruent form that structured interviews alone will not explore.

Qualitative research enables more context-sensitive understanding. Yet culture itself must be approached critically – it is neither homogeneous nor static but internally differentiated and shaped by power relations. Engaging with *culture* requires not only inclusion but critical reflection on whose knowledge is recognised and whose voices are amplified within global mental health research.

Epistemology and the question of method

Major theoretical traditions in psychiatry – psychodynamic, humanistic, existential – emerged not from controlled experimentation alone, but from sustained clinical engagement and philosophical reflection (Boyd *et al.*, 2012; Farber, 2010). These traditions expanded the field's conceptual vocabulary and opened up new ways of understanding subjectivity, suffering and the therapeutic relationship. The *role of philosophy* within mental health is both foundational and constraining: research practices are shaped by assumptions about the nature of the self, the definition of suffering and the criteria for valid knowledge (Stein *et al.*, 2024).

No methodological approach is philosophically neutral; each operates within a conceptual horizon that both enables and limits inquiry. Qualitative researchers bring assumptions about the primacy of lived experience; quantitative researchers bring assumptions about what can be reliably operationalised. Recognising this situatedness is not a counsel of relativism but a call for transparency. The distinction between qualitative and quantitative approaches is not one of rigour versus its absence, but of differing epistemological commitments, each with its own strengths and vulnerabilities (Johnson, Adkins and Chauvin, 2020).

Toward a pluralistic science

The integration of qualitative and quantitative approaches is best understood as *epistemological pluralism* – a principled engagement with different modes of inquiry.

Quantitative methods offer structure, generalisability and predictive capacity; qualitative methods offer depth, contextualisation and interpretive insight. Their integration involves ongoing negotiation between generalisation and particularity, standardisation and contextual sensitivity – a tension that is not a problem to be resolved but a condition inherent to the field (Leung, 2015).

In practice, *mixed-methods research* allows investigators to combine the explanatory reach of quantitative designs with the interpretive depth of qualitative approaches. Questions such as why an effective intervention fails to generalise across cultural settings or why patients disengage from a treatment with strong trial evidence, are rarely answerable by quantitative data alone. The history of psychiatric research illustrates this: many clinically important insights about recovery, stigma and the social determinants of mental illness emerged initially from qualitative and observational inquiry before being formalised and tested more broadly.

Clinical implications: a summary for practice

The arguments above carry concrete implications for psychiatrists and other medical professionals.

Assessment and formulation. Rating scales and structured interviews are necessary but not sufficient. A patient's score does not reveal how they understand their illness, what they fear or whether treatment aligns with their explanatory model. Asking "What do you think is causing this?" enriches the formulation and takes only minutes. Formulation – not diagnosis alone – should anchor treatment planning (Kleinman, Eisenberg and Good, 1978).

The diagnostic encounter. Communicating a diagnosis is a consequential event that can reorganise self-understanding, alter relationships and shape recovery. Clinicians should attend to how diagnoses are received, invite patients to articulate their responses and remain open to revisiting the formulation as understanding develops.

Culture and context. Cultural factors shape presentation, help-seeking and treatment engagement. Somatic presentations, spiritual explanatory frameworks or family-mediated care pathways may reflect culturally congruent expressions of distress. The DSM-5 Cultural Formulation Interview offers a structured but flexible tool for incorporating cultural assessment into routine practice (Lewis-Fernández *et al.*, 2014).

Research practice. Methodological choices should be guided by the research question. Questions of meaning, experience and context require qualitative approaches as primary methods, with attention to reflexivity, analytic transparency and rigour. *Mixed-methods* designs should engage genuinely with different epistemological perspectives, not merely append qualitative data to quantitative outcomes.

A closing reflection: holding the tension open

The task of mental health research is not to arrive at a final synthesis between measurement and meaning, but to remain reflectively engaged with their relationship. Mental health is a field constituted through biological processes, subjective experiences, cultural meanings and institutional practices. Quantitative methods organise this complexity; qualitative methods interpret and contextualise it. Neither provides complete access.

To ask *how* symptoms may be *measured* is indispensable; to ask *how* they are *experienced* is no less essential. Behind every score lies an interpretation, behind every diagnosis a narrative and behind every symptom a life embedded within networks of meaning and power. A science that measures without understanding risks precision at the cost of meaning.

The challenge is not to resolve the tension between approaches, but to *hold it open* – productively, critically and with sustained commitment to a more comprehensive understanding of mental health.

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Declaration Regarding the Use of Generative AI

The authors affirm that the manuscript was crafted without AI assistance in analysis, image creation or content generation, ensuring full accountability for its content.

References

- Andrade, C. (2024), "Rating patients in different languages: reliability and validity", *Indian Journal of Psychological Medicine*, Vol. 46 No. 3, pp. 268-269, doi: [10.1177/02537176241244457](https://doi.org/10.1177/02537176241244457).
- Beg, M.J. (2025), "Qualitative methods in mental health research: standards for ethical inquiry, research practice, and peer review", *Indian Journal of Psychological Medicine, Advance Online Publication*, doi: [10.1177/02537176251363817](https://doi.org/10.1177/02537176251363817).
- Boyd, C.M., Singh, S., Varadhan, R., Weiss, C.O., Sharma, R., Bass, E.B. and Puhan, M.A. (2012), "Challenges of quantitative approaches for assessing benefit and harm", *Methods for Benefit and Harm Assessment in Systematic Reviews*, Agency for Healthcare Research and Quality, Rockville, MD, available at: www.ncbi.nlm.nih.gov/books/NBK115749/
- Dahlberg, H. and Dahlberg, K. (2019), "The question of meaning – a momentous issue for qualitative research", *International Journal of Qualitative Studies on Health and Well-Being*, Vol. 14 No. 1, p. 1598723, doi: [10.1080/17482631.2019.1598723](https://doi.org/10.1080/17482631.2019.1598723).
- Farber, E.W. (2010), "Humanistic-existential psychotherapy competencies and the supervisory process", *Psychotherapy*, Vol. 47 No. 1, pp. 28-34, doi: [10.1037/a0018847](https://doi.org/10.1037/a0018847).
- Jablensky, A. (2016), "Psychiatric classifications: validity and utility", *World Psychiatry*, Vol. 15 No. 1, pp. 26-31, doi: [10.1002/wps.20284](https://doi.org/10.1002/wps.20284).
- Johnson, J.L., Adkins, D. and Chauvin, S. (2020), "A review of the quality indicators of rigor in qualitative research", *American Journal of Pharmaceutical Education*, Vol. 84 No. 1, p. 7120, doi: [10.5688/ajpe7120](https://doi.org/10.5688/ajpe7120).
- Kleinman, A., Eisenberg, L. and Good, B. (1978), "Culture, illness, and care: clinical lessons from anthropologic and cross-cultural research", *Annals of Internal Medicine*, Vol. 88 No. 2, pp. 251-258, doi: [10.7326/0003-4819-88-2-251](https://doi.org/10.7326/0003-4819-88-2-251).
- Leung, L. (2015), "Validity, reliability, and generalizability in qualitative research", *Journal of Family Medicine and Primary Care*, Vol. 4 No. 3, pp. 324-327, doi: [10.4103/2249-4863.161306](https://doi.org/10.4103/2249-4863.161306).
- Lewis-Fernández, R., Aggarwal, N.K., Bäärnhielm, S., Rohlf, H., Kirmayer, L.J., Weiss, M.G., Jadhav, S., Hinton, L., Alarcón, R.D., Bhugra, D. and Groen, S. (2014), "Culture and psychiatric evaluation: operationalizing cultural formulation for DSM-5", *Psychiatry: Interpersonal and Biological Processes*, Vol. 77 No. 2, pp. 130-154, doi: [10.1521/psyc.2014.77.2.130](https://doi.org/10.1521/psyc.2014.77.2.130).
- Mitra, S. and Chatterjee, S.S. (2026), "Should we expect the same mental health promotion campaigns to work in all settings? An argumentative review", *Global Health Promotion*, doi: [10.1177/17579759251410924](https://doi.org/10.1177/17579759251410924).
- Osborne, A. (2026), "Embracing pluralism: rethinking Western psychiatric models for equitable global mental health", *Culture, Medicine, and Psychiatry*, Vol. 50 No. 1, p. 18, doi: [10.1007/s11013-025-09966-9](https://doi.org/10.1007/s11013-025-09966-9).

Palinkas, L.A. (2014), "Qualitative and mixed methods in mental health services and implementation research", *Journal of Clinical Child & Adolescent Psychology*, Vol. 43 No. 6, pp. 851-861, doi: [10.1080/15374416.2014.910791](https://doi.org/10.1080/15374416.2014.910791).

Scognamiglio, P., Tully, P.J., Khosravi, M. and Monaco, F. (2023), "Psychometrics in psychiatry 2022: psychological therapy and psychosomatics", *Frontiers in Psychiatry*, Vol. 14, p. 1295716, doi: [10.3389/fpsyt.2023.1295716](https://doi.org/10.3389/fpsyt.2023.1295716).

Stein, D.J., Nielsen, K., Hartford, A., Gagné-Julien, A.M., Glackin, S., Friston, K., Maj, M., Zachar, P. and Aftab, A. (2024), "Philosophy of psychiatry: theoretical advances and clinical implications", *World Psychiatry*, Vol. 23 No. 2, pp. 215-232, doi: [10.1002/wps.21194](https://doi.org/10.1002/wps.21194).

Zegarra-Parodi, R., Loum, T., D'Alessandro, G., Baroni, F., Zweedijk, R., Schillinger, S., Conte, J., Mehl-Madrone, L. and Lunghi, C. (2025), "Indigenous epistemological frameworks and evidence-informed approaches to consciousness and body representations in osteopathic care", *Healthcare*, Vol. 13 No. 6, p. 586, doi: [10.3390/healthcare13060586](https://doi.org/10.3390/healthcare13060586).

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