

How to use quantitative and qualitative frameworks in whole systems research: detailed examples from two mixed-methods case studies

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Received: March 15, 2026; Revised: May 16, 2026; Accepted: May 31, 2026

ABSTRACT

Introduction Evaluating complex interventions such as complementary and alternative medicine (CAM), including traditional Chinese medicine (TCM), requires approaches that capture both context and outcomes. Whole systems research (WSR) employs mixed-methods designs to study these systems in real-world settings. **Methods** We highlight key methodological considerations for mixed-methods data collection and analysis, illustrated by two case studies: (1) a randomized controlled trial with an embedded process evaluation of spiritual healing for moderate depression; and (2) a cross-sectional survey of oncology providers with written comments ($n = 157$). **Results** In Case 1, spiritual healing showed potential benefit for adults with moderate depression. Adherence was high, with minimal dropout and timely questionnaire completion; the process evaluation linked this to close follow-up by the study nurse. In Case 2, communication about CAM differed across provider groups: CAM providers promoted integration with conventional care; physicians were more skeptical, citing limited efficacy evidence; and nurses expressed more positive attitudes. CAM providers and nurses favored strengthening communication between CAM and conventional providers, whereas physicians were less supportive. Qualitative comments enriched and contextualized these patterns. **Conclusion** Integrating qualitative contextual insights with quantitative outcomes yielded more comprehensive evidence than either method alone, enabling the operationalization of WSR. The detailed procedures for data collection and analysis provide a practical template for students and researchers new to mixed-methods research.

KEYWORDS

whole systems research, mixed-methods, complementary and alternative medicine, traditional Chinese medicine, process evaluation

CITE THIS ARTICLE

Stub T, Alræk T, Kristoffersen Agnete E. How to use quantitative and qualitative frameworks in whole systems research: detailed examples from two mixed-methods case studies. Evidence-Based Chinese Medicine and Technology Assessment, 2026, 2: 9570036. <https://doi.org/10.26599/eCMTA.2026.9570036>

1. Introduction

Complex interventions include having multiple interacting components, addressing multiple outcomes, and targeting different levels of change within complex systems.¹ Evaluating the effectiveness of such systems is inherently complex because they consist of interconnected elements that function as a network.² Whole systems research (WSR) refers to a healthcare approach that utilizes comprehensive knowledge and practices to support patients in achieving mental and physical well-being, ultimately restoring health.² This approach involves methods that encompass all aspects of a treatment modality or healthcare system, analyzed within the framework of its unique explanatory model.³ The elements in complex health systems cannot be evaluated in isolation, as their interactions are synergistic, meaning the system as a whole is greater than the sum of its parts.³ Consequently, research must focus on examining the entire package of care, including all elements of the provider's approach, rather than isolating individual components. In the context of complementary and alternative medicine (CAM), conducting WSR requires investigating everything a practitioner does during a consultation, from diagnostic methods to treatment strategies and patient interactions. Traditional Chinese medicine (TCM) is a whole system modality in addition to complex healthcare systems such as healing practices, Ayurvedic medicine, homeopathy, and naturopathic medicine.⁴ Even within conventional medicine, systems such as physiotherapy, psychotherapy, surgery, general practice, and nursing care are considered whole systems of healthcare, as they similarly

involve interconnected elements that contribute to patient outcomes.

This holistic approach acknowledges that health outcomes are influenced by a wide array of interconnected variables, many of which extend beyond the immediate provider-patient interaction.⁵ Given the complexity of these systems, research designs and methodologies must account for participants' philosophical values, the individualized and patient-centered nature of the modalities, and the participatory processes of diagnosis and treatment. These processes integrate the knowledge and skills of both patients and providers, reflecting the collaborative and dynamic nature of whole systems of care.³ WSR also emphasizes the importance of considering broader influences on health, including the perspectives and roles of family, friends, community, and environmental factors.⁶ Hence, WSR provides a framework for researchers to understand how complex healthcare systems, such as CAM and TCM, contribute to health and well-being, and the mixed-methods design provides a tool for evaluating and providing nuanced information about these complex modalities.

1.1. Mixed-methods design

Mixed-methods research is a recognized study design where the researcher mixes or combines quantitative and qualitative research techniques, methods, approaches, concepts and/or language within one research project.⁷ It allows the researcher to select and match design components that offer the best options to answer the research questions, and the design is a complement to traditional qualitative and quantitative research.^{8,9} A study showed that 18% (119/647) of health service research studies were classified as mixed-methods research.⁹ Comprehensiveness was the primary reason for choosing this design, as the researchers aimed to address a broader range of questions that could not be fully answered using quantitative methods alone.

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Hence, the researchers sought to employ qualitative methods to investigate the complexity of healthcare delivery.

Moreover, qualitative research can generate hypotheses for quantitative research and test the theoretical framework for a quantitative method.¹⁰ The qualitative approach enables researchers to understand participants and investigate how an intervention is implemented in practice.^{7,8} Both research approaches can provide information about different aspects of a phenomenon, addressing what it is, how it unfolds, and why it occurs.^{7,11}

A process evaluation is a qualitative approach commonly used to examine how a service, program, or intervention is implemented in real-world settings. It also explores the processes of impact and the influence of contextual factors. The aim is to provide insights to improve implementation and inform future practice. Hence, there are increasing calls for process evaluations alongside outcome evaluations of complex healthcare interventions.¹² In this paper, we use a WSR perspective focused on the intervention as a multicomponent whole (spiritual healing). We did not include contextual components such as patients' home environments or social networks. Moreover, we will demonstrate how a process evaluation provides nuanced insights and complements randomized controlled trials (RCTs) and cross-sectional studies.

1.2. RCTs

In clinical medicine, RCTs are widely regarded as the gold standard for evaluating the efficacy of interventions, as they minimize bias and reduce the likelihood of false conclusions.¹³ They are particularly well-suited to conducting rigorous assessments of complex health interventions.¹⁴ However, the design has also been criticized.¹⁵ Concerns have been raised about its tendency to overlook input from both patients and healthcare professionals.¹⁶ Additionally, RCTs are often criticized for being insensitive to the broader healthcare context.¹⁷ Critics argue that trials are artificial constructs that do not mirror real-world settings,¹³ and as a result, the design may fail to reflect the realities of clinical practice.¹¹

The value of incorporating qualitative research methods within clinical trials is widely acknowledged.^{15,18–20} Previous research has highlighted several ways in which qualitative methods can enhance trials.¹⁷ These include identifying and addressing challenges related to recruitment and retention,²¹ ensuring that RCT designs are tailored to the specific population and condition being studied,²² and facilitating the interpretation and implementation of trial findings by providing insights into contextual factors.²³ Additionally, qualitative methods can evaluate whether trial processes are appropriate.⁴ Such methods have also contributed to the design and execution of trials by assessing the fidelity and uptake of interventions, as well as exploring how and why these interventions succeed or fail.^{24,25} However, in practice, very few trials incorporate qualitative methods. A review of three trial registers from 1999 to 2016 found that less than 4% of trials reported using qualitative methods; trials of complex interventions were the most likely to do so.¹⁵

1.3. Strategies for implementation

Quantitative research, including cross-sectional studies, is commonly employed to evaluate intervention outcomes and enhance the generalizability of findings from qualitative studies.¹⁰ There are three primary strategies for integrating cross-sectional and qualitative studies: sequential, convergent, and embedded.²⁶ The sequential design is the most commonly used approach, used in 40% of mixed-methods studies, as reported in a methodological review.¹¹ In this approach, one research method follows the other, with each phase building upon or explaining/elaborating on the results of the previous phase. For example, a survey might be conducted first, followed by interviews to provide additional nuance to the findings. In contrast, the convergent design, utilized in 24% of mixed-methods studies,¹¹ involves conducting both methods simultaneously, and the findings are combined to provide a fuller and more nuanced understanding of the research problem. For instance, surveys and interviews might be conducted at the same time to capture different dimensions of the phenomenon under study. The embedded design, which is less common and accounts for 3% of mixed-methods studies,¹¹ involves one method being primary while the other serves a supple-

mentary role. For example, a quantitative study might include embedded qualitative interviews to add depth or context to the main findings. This paper focuses on sequential design and does not treat exploratory sequential or multiphase designs.

Mixed-methods research offers several advantages.²⁶ The integration of multiple methods, or triangulation, enhances the validity of findings by cross-checking and validating results. Further, triangulation can support the integration of qualitative and quantitative findings, assist researchers in refining their theoretical propositions, and clarify the foundations of their results. Additionally, it also provides a more comprehensive understanding of the research problem by capturing both trends through quantitative methods and narratives through qualitative approaches.¹⁰ Furthermore, it allows for a deeper contextual understanding by exploring the underlying reasons and factors influencing the phenomenon under study.²⁷ However, mixed-methods research also has its challenges. It requires expertise in both quantitative and qualitative methods, which can be demanding for researchers. Additionally, it is often time and resource-intensive, which requires careful planning and collaboration.⁷ At the National Research Center in Complementary and Alternative Medicine (NAFKAM), we address these challenges through collaboration among researchers with diverse research competencies on a mixed-methods project.

This paper aims to highlight key methodological considerations for conducting mixed-methods research, with a particular focus on data collection and analysis. It is especially designed to support students and researchers with limited experience in implementing mixed-methods designs. To illustrate these considerations, the paper draws on two studies (Case 1 and Case 2) that employ a mixed-methods approach,^{28,29} acknowledging the diversity of available designs.²⁷

2. Case 1: pilot RCT + process evaluation

This study employed a mixed-methods approach with a convergent design, including a pilot RCT with embedded process evaluation. Using a mixed method design we sought to test the feasibility of a pilot RCT study that investigates spiritual healing used in conjunction with standard care, as compared to standard care alone for adults with moderate depression. In a process evaluation, we delineated the participants' reflections on the treatments received within the study's framework, the perceived benefits and potential drawbacks and to the extent which the treatments met their initial expectations.

2.1. Introduction (RCT)

Many individuals with depression explore CAM, including spiritual healing which is understood as an energy-based therapeutic approach to healing. A spiritual healer uses the hands to balance and harmonize the body and thereby place the client in a position of self-healing.³⁰ The healing treatment focuses on the whole person (physically, psychologically, and emotionally) as well as the environmental factors (support from family, friends, community). This pilot RCT tested the feasibility of integrating spiritual healing with usual care versus usual care alone for adults with moderate depression. The embedded process evaluation captured participants' reflections on the study flow, treatments, and any adverse effects.

2.2. Methods (RCT)

Two parallel groups were randomized: 28 adults to spiritual healing + usual care ($n = 14$) or usual care alone ($n = 14$). Depression severity was assessed with the Beck Depression Inventory for Primary Care (BDI-PC 35) pre- and post-intervention.³¹

2.2.1. Intervention

The healing sessions followed usual practice, which included an initial health assessment with the healer. Then the healer holds her hands over the head, chest, knee, hip, and feet (over clothing) to adjust the energy flow of the participant. All participants followed their family physician's treatment plan.

Usual care comprised physician consultations, including lifestyle guidance, referrals to psychologists/psychiatrists, antidepressant prescriptions, and sick-leave recommendations.

2.2.2. Inclusion criteria

Adults ≥ 18 years with primary care–diagnosed moderate depression, Montgomery–Åsberg Depression Rating Scale (MADRS) score of 20–28,^{31,32} with symptoms ≥ 2 weeks.

2.2.3. Outcome and measurements

Primary outcomes were changes in the severity of depression measured by the BDI-PC 35,³¹ measured at baseline and at 8, 16, 26, and 52 weeks (Figure 1). The instrument is self-scored and includes questions such as: *Do you feel sad or unhappy? Do you feel guilty? Do you feel worse than anybody else?*

2.2.4. Informed consent, randomization, control group, allocation concealment

Primary care physicians screened candidates using MADRS and/or clinical observation. After written consent and baseline BDI, participants were randomized via Excel (version 2019, Microsoft Corp., Redmond, WA) with variable block sizes (2–6) to healing + usual care or usual care alone.³² Twenty-eight participants were enrolled. The intervention group received 10 healing sessions plus usual care; controls received usual care. Both groups completed the BDI; four were lost to follow-up (1 intervention, 3 control). Seven partici-

pants (5 intervention, 2 control group) were interviewed (Figure 1).

2.2.5. Data analysis (statistics)

Between-group differences in mean BDI at each time point were tested with independent-samples *t*-tests ($P < 0.05$). All analyses were performed using IBM SPSS Statistics (version 29, IBM Corp., Armonk, NY).

2.3. Results (RCT)

BDI scores showed significant changes in depression severity, with the intervention group showing the greatest mean difference from baseline (BDI 23.0) to week 16 (BDI 14.9), compared with the control group, which worsened from baseline (BDI 24.2) to week 16 (BDI 26.7).

2.4. Introduction (process evaluation)

Participants were invited to voluntary, semi-structured interviews at the end of the study period to explore their study experience.³³ They were asked to reflect on the treatments received, to the extent to which the treatments met their initial expectations, willingness to be randomized, recruitment speed, study adherence, and adverse effects. The participants were asked questions like: *Why did you participate in the study? What do you think about being placed in groups and not being able to choose the group yourself? How did you experience healing treatments? What kind of treatment did you receive from the doctor (medication, conversation)?*

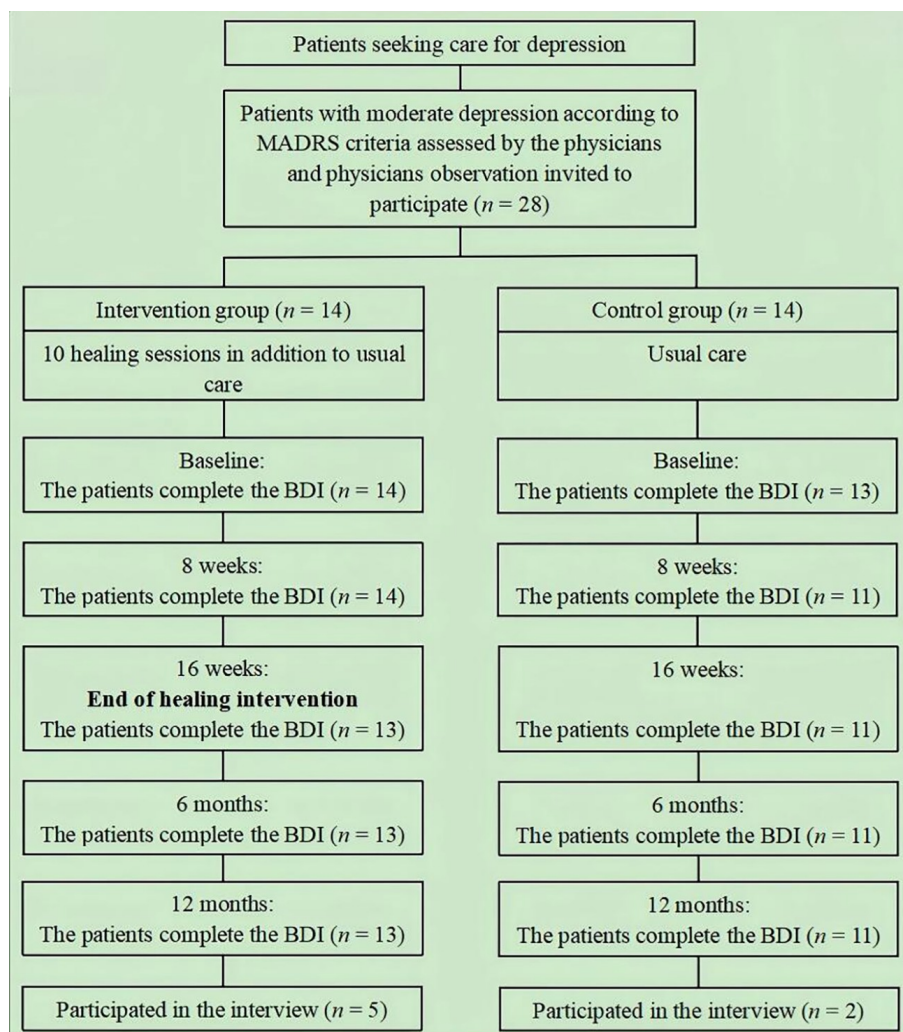


Figure 1 Flow chart of the inclusion process in the study

Notes: BDI: Beck Depression Inventory; MADRS: Montgomery–Åsberg Depression Rating Scale.

2.5. Methods (process evaluation)

2.5.1. Data collection

Seven participants were interviewed individually via Microsoft Teams (version 10.4.7, Microsoft Corp.). The interviews lasted 30 min, and notes were taken.

2.5.2. Data analysis

The data analysis was conducted according to conventional content analysis,³⁴ aligning categories with the aims of the process evaluation. First (TS) and last author (AEK) read the transcripts several times. The data were organized accordingly, and NVivo 1.61 (Qualitative Solutions Research Pty Ltd, Melbourne, Australia) was used for data management and analysis.³⁵

2.6. Results (process evaluation)

In this section, ID# reflects the participant's identification number.

• Participants' reflections on the interventions

Spiritual healing: All participants described positive healing experiences. ID16 kept an open mind and was surprised by how little *hocus-pocus* there was, noting a warm, pleasant atmosphere and even some separation anxiety when sessions ended. ID5 called the treatment *absolutely wonderful*, saying she was open and receptive. ID8 appreciated the time to talk at the start, felt the healer sensed what to address, and felt well cared for and remembered.

Usual care: Four participants, two controls (ID15, ID17) and two in the intervention group (ID5, ID16), were reassigned to new family physicians after enrollment; all were satisfied. As ID15 said, *I got a new doctor, and I was very happy with him*. She visited him two or three times during the study period.

• Willingness to be randomized and study adherence

Randomization was generally accepted, especially by those in the intervention group. ID28 said she would have been open to usual care alone for the chance to talk. Control group members were less enthusiastic but accepting; as ID15 noted, *that's just how it has to be. I was hoping for the other group, but this [group] was perfectly okay*.

A study nurse reminded participants by call or short message service (a text messaging service for mobile phones) to complete the BDI questionnaire at 8 and 16 weeks and at 6 and 12 months, providing the link. This was well received. ID17 said, *If not, I would never have remembered*. Retention was high; only one control participant was lost to follow-up. Most found the questionnaire manageable. ID5 found some items challenging and wished for a *not relevant* option. ID15 appreciated the brevity to maintain focus, while ID17 found it therapeutic and noticed she had stopped crying during the time spent completing the questionnaire.

• Adverse effects

No adverse effects were reported in the questionnaires. In interviews, three participants (ID15, ID16, ID28) mentioned fatigue after healing sessions.

2.7. Summary

Findings from the RCT component of this study suggest that spiritual healing may be a beneficial option for individuals with moderate depression. Process evaluation revealed that participants in both groups were satisfied with the interventions they received, as reflected in the high adherence rate. The study's success in preventing dropouts and ensuring timely completion of questionnaires was largely due to the close follow-up by the study nurse. Overall, the use of a mixed-methods design provided a more comprehensive and nuanced understanding compared to relying solely on one approach.

3. Case 2: cross-sectional study with embedded respondents' written comments

This study²⁸ employed a mixed-methods approach with a convergent design, including a cross-sectional study with embedded respondents' writ-

ten comments. The design allows for gathering more nuanced and in-depth information than using one of the methods alone.

3.1. Introduction (cross-sectional study)

Effective interdisciplinary communication improves care quality. This study aimed to (I) compare conventional providers (oncology doctors/nurses, family physicians) and CAM providers (massage, acupuncture, reflexology) on communication with cancer patients; and (II) assess CAM and conventional communication and cooperation.

3.2. Methods (cross-sectional study)

A self-administered, questionnaire-based cross-sectional study with structured and open-ended items.

3.2.1. The sample

A total of 1341 healthcare providers [conventional (709) and CAM providers (632)] were invited to participate in this study. The final sample consisted of 606 respondents: 152 medical doctors (MDs), 47 dual-trained (MD + CAM), 91 nurses, and 316 CAM providers (massage therapists, acupuncturists, reflexologists) (Figure 2).

3.2.2. Questionnaire content

Developed from a literature review,³⁶ the survey had 86 items across eight domains: inclusion, patient communication, clinical risk, perceptions of CAM and conventional cancer care, modality information, demographics, practice setting, and ethnicity.

3.2.3. Data collection

Using Dillman procedures,³⁷ a study letter was sent to possible participants, then a survey link one week later, followed by reminder emails at one-week intervals. Physicians received postal questionnaires and could respond by post or email.

3.2.4. Data analysis (statistics)

Descriptive statistics were computed. Chi-square, Fisher's exact, and logistic regression were used to analyze binary outcomes; analysis of variance (ANOVA) was used for continuous outcomes. Statistical significance was set at $P < 0.05$ (with no adjustment for multiple comparisons). All analyses were performed using IBM SPSS Statistics (version 19, IBM Corp.).

3.3. Respondents' written comments

Written comments from 157 respondents constituted the data for this part of the study.

3.3.1. Data collection

Four open-ended questions invited free-text responses: (I) What else could improve communication between CAM and conventional providers? (II) What outcomes cancer patients expect from complementary modalities? (III) How do respondents advise patients about CAM? (IV) How do respondents advise patients about conventional treatment?

3.3.2. Data analysis

Comments were analyzed using descriptive qualitative analysis and the data was organized to reflect participants' experiences.³⁸ The approach was data-driven and aimed to provide nuanced insight.¹⁰

3.4. Results

For illustration, we present responses to two questions: *How do you advise cancer patients about CAM modalities? What else could improve communication between conventional and CAM providers?*

Only 16% of medical doctors (MDs) and 18% of nurses reported being very comfortable answering questions about CAM, compared with 60% of

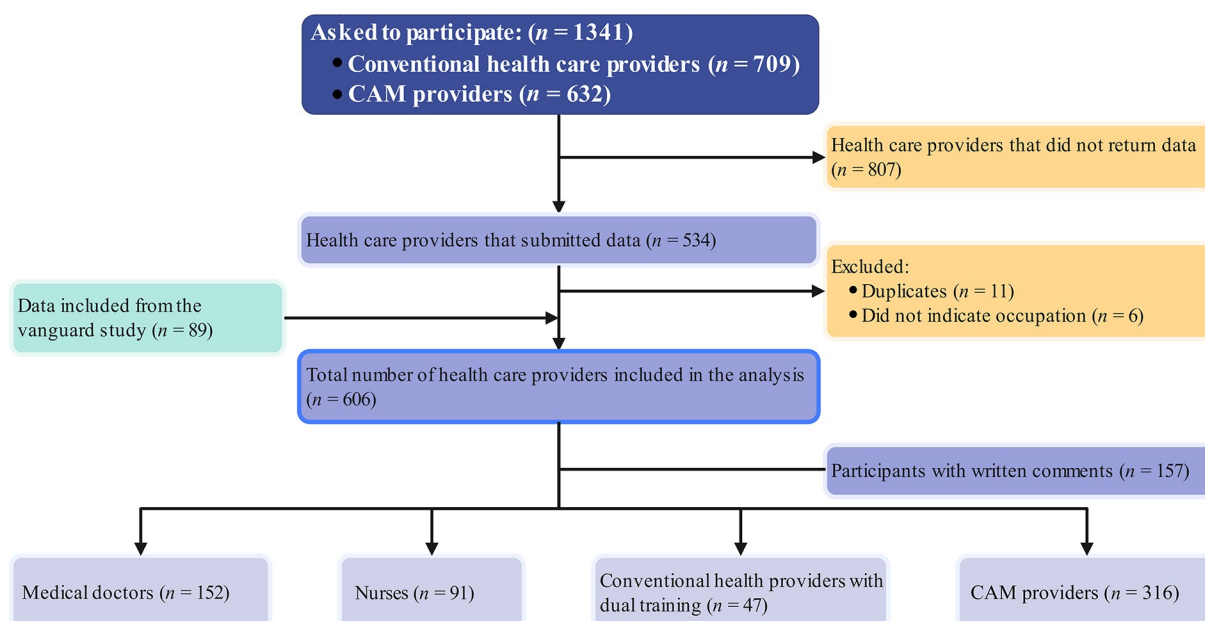


Figure 2 Flow chart of the inclusion process for the cross-sectional study

Notes: CAM: complementary and alternative medicine.

dual-trained MDs and 71% of CAM providers ($P < 0.0001$). Additional comments were provided by MDs ($n = 41$), nurses ($n = 19$), dual-trained providers ($n = 5$), and CAM providers ($n = 34$). When advising about CAM, many said their guidance depended on the specific modality and their own knowledge and experience: *My advice depends on my knowledge and experience with the modality of my patient's choice* (MD). Safety and patient autonomy were frequently emphasized: *If harmless, I support their choice* (MD). Another noted: *I support my patients in whatever they choose* (Nurse).

Regarding ways to improve communication, support for including CAM providers in conventional practice (and including conventional providers in CAM practice) was 55% among MDs, 85% among nurses, 100% among dual-trained MDs, and 99% among CAM providers ($P < 0.0001$). Respondents called for acceptance, respect, and more research and alignment of CAM views of disease with conventional medicine and recognition of professional limitations. Appeals for greater tolerance were common as illustrated: *Listen to and hold each other accountable, lower the brick wall, and ease the war atmosphere* (MD). Education and collaboration were highlighted as key strategies: one acupuncturist noted that bachelor-level acupuncture training includes conventional medicine, which may facilitate interprofessional communication, and a dual-trained provider suggested *mutual workshops, networks, and seminars* to improve interdisciplinary communication and cooperation.

3.5. Summary

Conventional and CAM providers differed in their communication with cancer patients about CAM. CAM providers encouraged combining CAM and conventional treatments, while MDs were less supportive. Nurses, however, expressed more positive attitudes toward CAM. Findings from the respondents' written comments provide depth to the overall findings and provide a more nuanced and comprehensive picture of the field.

4. Discussion

This paper demonstrates that a mixed-methods design can operationalize WSR by linking measurable and relevant outcomes with the lived context of care.⁸ Across both case studies, integrating quantitative and qualitative data produced findings that were more interpretable, actionable, and relevant to

real-world implementation than from either method alone.⁹ The Case 1 study used a mixed-methods design with complementary but distinct roles for the quantitative and qualitative components.²⁷ The quantitative approach provided the primary efficacy test, using repeated BDI assessments to evaluate changes in depression severity and differences between randomized groups. In contrast, the qualitative approach served as a process and acceptability evaluation. Through open-ended questions (expectations, willingness to be randomized, perceived benefits and adverse effects, and experiences of both healing treatments and usual medical care) we sought to contextualize and interpret the quantitative results.¹⁴ The qualitative insights were not used to determine clinical effectiveness; rather, they helped explain patterns in outcomes and adherence, clarified the acceptability of trial procedures (including group allocation), and identified considerations for implementation in routine care.³⁹ This integration strengthens the interpretation of the efficacy data and guides refinements for future studies.¹⁰

In Case 2, the cross-sectional survey mapped differences in attitudes and communication across provider groups, and the written comments supplied concrete, practice-oriented suggestions for inter-disciplinary communication and collaboration.

This illustrates how mixed-methods research offers a robust framework for understanding how complex healthcare systems, such as CAM and TCM, contribute to health and well-being.²⁶ In an RCT,³⁹ comparing acupuncture with standard care, the acupuncture group did not show better quality of life or fewer chemotherapy side effects. To better understand participants' perspectives (breast cancer patients) on quality of life during chemotherapy and the perceived effects of acupuncture, a qualitative interview study was conducted within a mixed-methods design. Most women in both groups reported that their quality of life during chemotherapy was better than anticipated. In the acupuncture group, all participants described sessions as relaxing and beneficial. Across groups, developing coping strategies, such as maintaining a positive outlook, choosing supportive social contacts, and staying as active as possible, was viewed as essential for managing the diagnosis and treatment side effects. These nuanced insights suggest that future studies should focus more on coping processes and the reduction of acute side effects. This is in line with another RCT,⁴⁰ that aimed to describe health changes among postmenopausal women receiving acupuncture for hot flashes. Many women reported substantial reductions in the frequency and intensity of hot flashes, both day and night. The authors concluded that further analysis of the rela-

tionship between bodily experiences could help generate hypotheses or models for how acupuncture effects are mediated within complex bodily systems and inform the development of outcome measures relevant to acupuncture studies.

Another mixed-methods study integrated semi-structured interviews with a two-arm RCT in diabetic peripheral neuropathy (DPN).⁴¹ Many participants expressed dissatisfaction with limited treatment options and perceived gaps in medical care, and wished to reduce medication. Acceptance of acupuncture was high, particularly among those aiming to decrease medication use. The qualitative findings were consistent with the RCT results. By integrating both quantitative and qualitative data, this enables researchers to address a broader range of questions that cannot be fully explored using a single method.²⁷

According to Chinese scientific literature,⁴² qualitative research is well-suited for TCM in several ways: (I) exploring complex TCM practices, such as identifying key elements in the diagnosis and treatment process; (II) examining the attitudes, beliefs, expectations, and experiences of patients, providers, and family members regarding specific modalities or phenomena, for example, providers' experiences delivering acupuncture in public and private sectors;⁴³ (III) understanding differing perspectives on conflicting phenomena, such as the identity information and psychosocial needs of Chinese immigrant cancer patients;⁴⁴ and (IV) providing in-depth insights that complement quantitative data collected in clinical trials.

This research design is particularly valuable for investigating the complexity of whole systems and healthcare delivery, as it provides nuanced insights into complex network modalities.³ Mixed-methods research not only evaluates complex systems but also offers a way to cross-check and validate data through methodological triangulation, enhancing the reliability of findings.⁴⁵

The mixed-method design captures both trends and narratives, offering a contextual understanding of the research questions while exploring underlying reasons and motivations.⁴⁶ The drawbacks are that it requires researchers to be experienced in both methods, and it is time-consuming to conduct.²⁷ To further advance mixed-methods research, future studies should focus on refining these approaches by incorporating diverse qualitative methods beyond interviews, such as photovoice methodology, to enrich the depth and breadth of data collection.⁴⁷ Another limitation is that we did not collect data on participants' home environments or social networks. Therefore, our WSR analysis does not address contextual mechanisms outside the clinical encounter. Future studies should integrate these elements.

5. Conclusion

This paper demonstrates how mixed-methods research can guide clinical practice, strengthen interprofessional collaboration, and inform future research agendas. The design delineates contextual factors that influence outcomes, which may improve the evaluation and delivery of care in complex health systems. Thereby yield more comprehensive, nuanced information than either method alone. Information that is essential for operationalizing WSR research. The detailed procedures for data collection and analysis offer a practical template for students and researchers new to mixed-methods.

Funding

This study was funded inhouse by NAFKAM – Norway's National Research Center in Complementary and Alternative Medicine. UiT, the Arctic University of Norway, Tromsø, Norway.

Data Availability

Additional data related to this paper may be obtained from the corresponding author upon reasonable request.

Author Contribution Statement

Trine Stub: Conceptualization, data curation, methodology, software, for-

mal analysis, visualization, writing – original draft, and writing – review and editing. **Terje Alræk:** Data curation and writing – review and editing. **Agnete E. Kristoffersen:** Writing – review and editing.

Use of AI Statement

None.

Declaration of Competing Interest

The first two authors are editorial board members of *Evidence-Based Chinese Medicine and Technology Assessment*. They have not participated in the peer-review process or the final decision-making for this manuscript, and they declare no other competing interests.

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