

**USING  
RESEARCH  
IN COUNSELLING  
AND PSYCHOTHERAPY**

**JOHN MCLEOD**



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# 1

## Practitioner Attitudes to Research

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### Introduction

The background to everything that follows in this book is the concept of Evidence Based Practice (EBP), an idea and policy strategy that emerged within medicine and health care in the 1960s. Historically, medical treatments had been based on a mixture of careful observation and theorising that was handed down from one generation of doctors to the next, with minimal empirical evaluation of effectiveness. In fact, as Wootton (2006) has demonstrated, until the middle of the twentieth century, it could be argued that medicine, overall, did more harm than good. By that time, rigorous scientific experimentation, the collection of health statistics, and the availability of potent interventions such as penicillin, meant that health care could begin to draw on a body of reliable scientific evidence. In the closing decades of the century, spiralling health costs associated with the development of new treatments, heightened public expectations, and an ageing population meant that it was essential for government and private health providers to find some way of making rational choices about which treatments were most cost-effective for which condition. Evidence Based Practice

offered a positive solution to this set of dilemmas – whenever possible, treatment would be informed by research evidence.

It is hard to argue with the basic concept of EBP. However, implementing an evidence-based approach in front-line health care is another matter. A classic, widely cited, definition of EBP is:

the conscientious, explicit and judicious use of current best evidence in decision-making about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external evidence from systematic research... [C]linical expertise [involves] the thoughtful identification and compassionate use of individual patients' predicaments, rights and preferences. (Sackett et al., 1996: 71)

This definition raises many questions, all of which are familiar to any practitioner. How do we know what 'current best evidence' consists of? 'Clinical expertise' comprises a complex and subtle blend of personal and professional experience – how can this be 'integrated' with research evidence? How do we understand the difference between 'judicious' and non-judicious use of evidence? What happens if the patient's preferences contradict the treatment recommended by the research evidence?

Gradually, the influence of Evidence Based Practice spread from health care to social care, to education, and to criminal justice. By the 1980s, there was sufficient research evidence available in the field of psychotherapy for EBP to be implemented in a meaningful way within that discipline. What this book is about is the struggle that has taken place since that time, within the field of counselling and psychotherapy, around the question of how best to make 'judicious' use of research findings in order to provide better therapy for clients.

Compared to medicine, counselling and psychotherapy has always been a tough area for proponents of Evidence Based Practice. In medicine, there are many key variables that can be objectively measured – temperature, heart rate, blood pressure, and mortality. By contrast, in psychotherapy there is a lack of such measures. Psychotherapy depends to a large extent on the quality of the therapeutic relationship. It is a complex intervention that usually unfolds over a considerable period of time. It is not possible to give the patient a pill and see what happens over the next hour. It is not possible to devise meaningful placebo treatments that can be delivered in double blind trials. As a result of these and other factors, there has been a great deal of resistance to EBP within the psychotherapy profession.

## Mapping practitioner attitudes to research

To appreciate the underlying issues that have shaped the current relationship between research and practice in counselling and psychotherapy, it is necessary to understand how therapists view research, how they feel about it, and how they engage with it. The following sections of this chapter offer a map of that territory.

We will look at the methodologies that have been used to collect data on therapist attitudes, and at the conclusions that have emerged from studies that have applied these methods with different samples of therapists.

Three contrasting research approaches have been used within this area of inquiry: questionnaires, interviews, and performance measures (e.g., counting numbers of publications produced by practitioners). It is an area in which a substantial amount of research has been carried out. In addition, there exist relevant findings from studies of cognate professional groups, such as nurses or social workers. Unfortunately, as far as I know, no one has conducted a systematic review of research studies of counsellor and psychotherapist attitudes to research. This is a pity, because such a project would be valuable in both consolidating knowledge within this topic area and providing an agenda for future research. For reasons of space the discussion that follows, within this section of the present book, cannot claim to represent a comprehensive systematic review of all relevant studies. The intention, instead, has been to indicate key themes, highlight some of the main conclusions that can be drawn, and point readers in the direction of further sources.

## Questionnaire measures

In relation to the use of questionnaires, these research tools have been applied to one set of questions that are fairly tightly focused, and another set of questions that are of broader significance. Tightly focused questionnaires have considered the issue of research competence, defined in terms of ‘self-efficacy’ – how competent the individual believes that he or she is in their ability to undertake various research tasks. Questionnaires of this type ask respondents to rate their level of confidence (e.g., on a 0–100 scale) in relation to statements that reflect key research tasks. Examples of typical items are: ‘Follow ethical principles of research’, ‘Generate researchable questions’, and ‘Knowing which statistics to use’. At the present time, there are three questionnaires that have been developed to assess researcher self-efficacy. These measures are described and evaluated in a useful paper by Forester, Kahn, and Hesson-McInnis (2004). Examples of studies that have employed such measures, for instance, to explore the outcomes of research training, can be found in Gelso et al. (2013). It is important to acknowledge that researcher self-efficacy represents just one aspect of practitioner attitudes to research. However, it is a vital aspect of such attitudes, because if a counsellor or psychotherapist defines himself or herself as incompetent or not research-literate, they are not likely to want to use research to inform their practice. Unfortunately, at the present time such scales have only been used in studies that have investigated the outcomes of primary research training. It would be interesting to know about the general research self-efficacy/confidence of practitioners at later stages in their careers.

Linked to the topic of researcher self-efficacy is the actual research knowledge that therapists have available to them, to use to inform their practice. This issue has been explored by Boisvert and Faust (2006) and Stumpf, Higa-McMillan, and

Chorpita (2009) through questionnaires that tested the knowledge base of clinicians, and in an open-ended, online survey questionnaire by Ogilvie, Abreu, and Safran (2005). There is not sufficient research around this area to arrive at any firm conclusions. What seems to be apparent in the findings of these studies, though, is that therapist knowledge of research is patchy – they exhibit in-depth knowledge and curiosity in respect of areas of research that are of particular relevance to them, while having a very limited understanding of other research domains. In the Boisvert and Faust (2006) study, some therapists appeared to have a highly developed awareness of research findings, while others had a limited knowledge base. However, these differences did not seem to be related to years since training, occupational setting, or any of the other demographic factors that were assessed in the study. It is perhaps worth noting that the findings reported by Boisvert and Faust (2006) need to be interpreted in the context of an earlier study that they carried out, in which the same knowledge test was administered to leading researchers, who only agreed on the correct answer 50% of the time (Boisvert & Faust, 2003). The relevance and impact of the actual level of research knowledge available to therapists was also explored in a study by Safran, Abreu, Ogilvie, and DeMaria (2011), who carried out a survey of attitudes to research, and the relevance of research for practice, of therapists who were members of the Society for Psychotherapy Research (SPR). This was a sample of therapists who undoubtedly possessed a high level of interest and knowledge around research findings. Nevertheless, these individuals did not differ from non-researcher colleagues in reporting that research findings had a very limited impact as a source of influence on their practice.

Other questionnaire measures have been developed to look at therapist attitudes to research more widely. Several of these questionnaires have consisted of attitude questions developed for one-off use in a particular study (e.g., Dutch & Ratanasiripong, 2016; Gyani, Shafran, Myles, & Rose, 2014; Morrow-Bradley & Elliott, 1986; Ogrodniczuk, Piper, Joyce, Lau, & Sochting, 2010; Safran, Abreu, Ogilvie, & DeMaria, 2011). Some of the more recent therapist survey questionnaires have borrowed items from the Morrow-Bradley and Elliott (1986) questionnaire. Such scales produce valuable data, but their use in only a single study makes it hard both to know whether they are in fact measuring what they claim to measure (validity) and to accumulate knowledge by comparing findings from different studies. As a result, there has been a tendency in more recent studies to use standardised attitude-to-research scales that are supported by evidence of reliability and validity. These measures make a particularly important contribution to our understanding of the relationship between research and practice, because the process of developing such scales involves making a systematic effort to map all possible aspects of the phenomenon.

One key finding that has emerged, in all of the therapist attitude-to-research studies listed in the previous paragraph, is that experienced therapists report that research evidence, and information and insight gleaned from research papers, have a relatively low level of influence on their practice, compared to other sources of learning such as experience with clients, supervision, speaking to colleagues, or reading books. Another important theme is that practitioners express dissatisfaction

with the kind of research that has been carried out, in terms of clinical relevance and clarity of reporting of results.

Moving on now to consider the use of standardised measures of attitudes to research, a great deal can be learned by noting the achievements and challenges associated with the Barriers to Research Utilization scale, which has been widely used in the field of nursing (Kajermo et al., 2010). The BARRIERS scale consists of 29 items on different aspects of research utilisation. Statements are rated on a four-point scale (1 = to no extent, 2 = to a little extent, 3 = to a moderate extent, 4 = to a great extent); respondents can also choose a 'no opinion' alternative. It measures four dimensions of research attitude:

- *research values, skills, and awareness* (typical items: 'Unaware of the research', 'Does not feel capable of evaluating the quality of the research');
- *barriers and limitations associated with the work setting* (typical items: 'There is insufficient time on the job to implement new ideas', 'Do not have time to read research', 'Not enough authority to change patient care procedures');
- *qualities of the research* (typical items: 'Uncertain whether to believe the results of the research', 'The conclusions drawn from the research are not justified');
- *presentation and accessibility of the research* (typical items: 'The statistical analyses are not understandable', 'Research reports/articles are not readily available', 'Implications for practice are not made clear').

The relevance of the BARRIERS scale, for counsellors and psychotherapists, is that the attitude dimensions that it describes are basically the same as those emerging from studies of therapists. It is therefore clear that the difficulties experienced by counsellors and psychotherapists in terms of using research knowledge are not unique to that profession, but in fact reflect more general characteristics of professional practice in contemporary society (similar studies and scales can be found in research on other professions, such as medicine, social work, and teaching). What the BARRIERS scale tells us is that some of the problem lies in the confidence and competence of the practitioners; other difficulties arise from the characteristics of the workplace; and yet further issues are linked to the ways in which research itself is carried out and reported. In other words, the research–practice challenge is multi-faceted, with the implications that different solutions are required in respect of different factors. The final point that can be made about the BARRIERS scale is that, like other scales in this area, it is predominantly negatively framed, consisting of questions about problems and difficulties rather than opportunities and possibilities. Obviously, it is vital to be able to identify barriers and difficulties. But, at the same time, there may be a tendency for such scales to reify problems, rather than open up solutions. This is exactly the conclusion reached by Kajermo et al. (2010) in their review of the use of the BARRIERS scale over a 20-year period: 'it has not been used to ... inform the development of strategies and interventions to promote research use' (p. 20).

Within the field of counselling and psychotherapy, there are several standardised measures that have been devised to assess practitioner attitudes to research. Some of

these scales evaluate therapists' positions in relation to specific activities or aspects of research-informed practice, such outcome monitoring and use of Evidence Based Practice protocols and treatment manuals. The Outcome Measurement Questionnaire (OMQ) and the Clinician Readiness for Measuring Outcomes Scale (CReMOS) have been used to assess therapist attitudes to using routine feedback and outcome monitoring as part of their practice (Smits, Claes, Stinckens, & Smits, 2015). The Clinician Readiness for Measuring Outcomes Scale (CReMOS; Bowman, Lannin, Cook, & McCluskey, 2009) is a 30-item scale that draws on the widely known transtheoretical Stages of Change model to examine the point that the person has reached in relation to incorporating an outcome measure into their practice (Levesque, Prochaska, Prochaska, Dewart, Hamby, & Weeks, 2001; Parker & Parikh, 2001; Prochaska & DiClemente, 1983; Prochaska, Prochaska, & Levesque, 2001). Items in this scale include:

- 'I know my interventions work; I don't need to measure them' (pre-contemplation: no perceived need to change).
- 'Measuring outcomes would be good if it didn't mean spending time doing extra paperwork' (contemplation: aware of problem but no commitment to take action).
- 'I have had someone teach me how to search electronic databases to locate relevant outcome measures for my clients' (preparation: preparing for action/initial behaviour change).
- 'I have trialled some outcome measures with my clients' (action stage).
- 'I have been measuring outcomes with my clients for at least 6 months' (maintenance).

The Evidence-Based Practice Attitude Scale (EBPAS; Aarons, 2004; Aarons, Cafri, Lugo, & Sawitzsky, 2012; Ashcraft et al., 2011) provides information on eight dimensions of therapist attitudes to integrating research-based procedures into their work with clients: limitations, fit, monitoring, balance, burden, job security, organisational support, and use of feedback. Some of the items within the 'limitations' section of the scale are: 'EBP detracts from truly connecting with your clients', 'EBP makes it harder to develop a strong working alliance', 'EBP is too simplistic', and 'EBP is not useful for clients with multiple problems'. In a sample of experienced therapists in the USA, Aarons et al. (2012) found that the majority tended to *disagree* with such statements, indicating a broad level of support for EBP. However, this support was qualified – these therapists indicated that they would be more likely to use EBP if their clients requested it and if they were offered organisational time and support to learn EBP techniques. A further scale that accesses similar information is the Attitudes Toward Psychotherapy Treatment Manuals scale (Addis & Krasnow, 2000; Ashcraft et al., 2011).

Another important dimension of therapist attitudes to research is concerned with willingness to take part in a research study that involves collecting data on one's own practice with clients. The Attitudes to Psychotherapy Research Questionnaire (APRQ; Taubner, Klasen, & Munder, 2016) was developed to investigate this area of research attitudes. The items in the APRQ provide a sensitive and nuanced mapping of different and contradictory aspects of the decision to be involved in research. For example, positive items include:

- I think that the communication with researchers is stimulating.
- By participating in psychotherapy research, I can learn something new.
- Participation in psychotherapy research enables a positive communication among colleagues.
- Patients benefit from participating in psychotherapy research.

On the other hand:

- The intimacy of therapeutic relationships is strongly impaired by research.
- Research takes away the patients' chance to find a place that only deals with him/her.
- I fear that research results could be used against psychotherapy for political reasons.
- I am afraid to embarrass myself by participating in psychotherapy research.
- I am afraid of negative evaluation of my work by participating in psychotherapy research.
- Participation in psychotherapy research takes away spare time.
- Psychotherapy research means unpaid work for me.

Despite these concerns, therapists appear on the whole to come out in favour of research participation. In a survey of psychoanalytic, psychodynamic and CBT therapists in Germany, Taubner et al. (2016) found that 50% indicated that they would participate in psychotherapy research, with 38% undecided and 12% expressing unwillingness. The majority of participants (84%) were willing to give questionnaires to their patients, and 63% would agree to audiotape sessions.

## Interview-based studies

A major advantage of survey questionnaires is that they can be readily distributed to large numbers of participants, and the results can be statistically analysed to identify patterns and trends. The main disadvantages of surveys are that they cannot reflect the complexity of the views and experiences of participants, and that informants can only reply to the questions that are asked – additional information that they might offer cannot be harvested. Interviews with therapists therefore provide a valuable adjunct to survey methods, and may even be used to inform the design of survey questionnaires. Relatively few studies have been carried out using qualitative research to explore therapist views and experiences around their use of research. Individual interviews have been used in studies by Cohen, Sargent, and Sechrest (1986), Gyani, Shafran, Rose, and Lee (2015) and Stewart, Stirman and Chambless (2012). Focus-group interviews were employed by Nelson, Steele, and Mize (2006), while Pagoto, Spring, Coups, Mulvaney, Coutu, and Ozakinci (2007) collected qualitative data through open-ended written questions to members of a professional email listserv.

The potential value of this type of methodological approach can be illustrated by looking in some detail at a qualitative interview study by Stewart, Stirman, and Chambless (2012) which encompasses themes found in similar studies, but goes

beyond these other studies in the depth of understanding that was attained and can therefore be regarded as an ‘exemplar’ study (McLeod, 2014).

Stewart et al. (2012) interviewed 25 experienced therapists in private practice, based in an urban area in the USA, about their attitudes to research, in particular empirically supported treatment packages (ESTs) – treatment protocols that had been shown to be effective in randomised controlled trials. All of these practitioners had completed Doctoral studies and research earlier in their careers. They worked with a wide range of client problems, and all of them described themselves as having evolved an eclectic way of working, based in the specific model that they had learned during training, but being open to new ideas and methods. Any attempt to summarise the whole of the analysis carried out by Stewart et al. (2012) would run the risk of missing the point and distinctive role of qualitative research, which is to generate a richly textured, nuanced account of a phenomenon that captures the experience and ‘voice’ of informants. Instead, a more adequate sense of what came out of this study can be conveyed through reflection on the following excerpts.

A key theme, within the views held by these therapists about research, was that: ‘empirical data are good (especially when there is a need) but have to fit in my framework’:

Many of the clinicians noted positive aspects of research, specifically that it is important for them to know what works. As one clinician explained, ‘There’s part of me that thinks that it makes sense, you would want treatment to have some empirical basis, want people to be helped, some measurement about how and that they are helped, more than an intuitive sense that you are helping people. That’s a positive in that way.’ Although positive about the general idea of ESTs, clinicians indicated that it would be most helpful to them to learn whether and how they could integrate them into their practice: ‘I’d have to see what it was and if it had real bearing on my work. I’m not closed to it, it’s important to know what works, but what I’d think would be “let me learn this technique, let me see how it works, and I will do with it what I need to in order to apply it to my own practice”’. Overall, clinicians do not object to the general idea of empirical data. ESTs are acceptable, but only if not taken literally (e.g., rigidly following treatment manuals) and only if they can incorporate specific strategies and components of ESTs into their standard eclectic practice. Several clinicians also noted that they seek out new information when they are ‘stuck’ or when they are presented with diagnoses with which they have minimal experience. For some, they sought out the research literature: ‘Actually this is a case where I went to the research and did some reading on eating disorders, particularly on binge-eating disorder, and the consequence was that I was more cognitive-behavioral, more concrete, and more directive than I might be in other circumstances.’ (pp. 103–105)

However, the notion that ‘empirical data are good’ existed in tension with a quite different belief: ‘research misses the human component of therapy’:

Clinicians maintained that the very nature of research neglects the human and interpersonal component of therapy. Many noted that it is not possible to quantify the interpersonal sphere of therapy: ‘It’s impossible to test for all of the nuances that

happen in a human relationship.' Clinicians' comments also revealed beliefs that manualised treatment is inimical to maintaining a human connection with a patient. As one clinician declared: 'I want to have the most informed therapy I can, but for me there is a bell curve where I lose the human connection with my client if I'm too much in the numbers, in the manuals, and what's validated, or the protocol. So I take it up to a point, and then I need to step back.' Clinicians noted repeatedly that therapy is inherently a subjective phenomenon in an interpersonal setting that cannot be fully understood by research. For example, 'ESTs can provide outlines and basic rules. After that it's a person that has to apply that in an interpersonal setting.' (p. 105)

It is worth reading these passages carefully (and indeed, reading the whole paper by Stewart et al., 2012). What comes across, more powerfully and clearly than in questionnaire surveys, is a moral position: empirically supported treatment approaches are valuable if they meet the needs of this client, in the room with me right here and now. And, further, they are not valuable if they cause the therapist to 'lose the human connection' with that client. Clearly, there is a balancing act here. But it is not a matter of balancing competing sources of cognitive evidence. Rather, it is a balance or point of dialogue between quite different ways of knowing.

## Performance-based measures

A valuable approach to collecting information on the ways in which counsellors and psychotherapists use research is to observe or measure their actual behaviour. There are many 'performance' or behavioural indicators that are potentially of great relevance. For example, attendance at research training workshops, seminars, or conferences reflects the willingness of a therapist to devote precious time to learning about research. So far, research that has attempted to map therapist involvement in research has not used performance measures in a systematic or extensive manner. Examples of the use of this research strategy include survey questions about the number of research papers read in the last month (Morrow-Bradley & Elliott, 1986), prevalence of use of client feedback and monitoring tools (Hatfield & Ogles, 2004, 2007), and counting the number of published articles or conference presentations that an individual has published (Galassi, Brooks, Stoltz, & Trexler, 1986; Gordon & Hanley, 2013; Morrow-Bradley & Elliott, 1986).

## Conclusions

Mapping tools and studies have made it possible to assess many different aspects of the ways that counsellors and psychotherapists use research to inform their practice. It is not easy to draw general conclusions from this body of research, because most scales or interview schedules have been used on a limited basis, with specific samples of therapists. Nevertheless, some trends are apparent. The most striking finding

from these mapping projects is the ‘glass half full’ dilemma. Is the glass half full (i.e., therapists are committed to using research to enhance practice) or is it half empty (therapists lack interest in research, and view it as lacking relevance to their practice)? Both conclusions can be justified in relation to survey and interview findings. On the whole, the people who have been carrying out these studies are academic researchers, so there has been a tendency to interpret findings as reflecting a worrying ‘gap’ between research and practice. For my own part, I am more inclined to take an optimistic view of the relationship between research and practice that is disclosed in these studies. In the light of the discussion later in the book (Chapter 4) of the relevance of different ‘knowledges’ for therapy practice, it is reassuring that therapists acknowledge the value of research while at the same time retaining a sceptical distance from it. My personal reading of the accumulation of 30 years of mapping studies is that practitioners are gradually becoming more positive about the role of research, and more appreciative of the possibilities it opens up.

There are two further themes that emerge from these mapping studies. The first is that CBT therapists are somewhat more enthusiastic about research than are colleagues from other therapy orientations (see, for example, Gyani et al., 2014; Taubner et al., 2016). This does not mean that non-CBT therapists hold negative attitudes; just that their attitudes are less positive. This finding is not unexpected given the emphasis on research and measurement that has always existed within the CBT professional community. The second theme is that therapist judgements about research are not merely a matter of personal beliefs and attitudes, but also depend on the occupational context in which they work. Research is viewed as a good thing if it is used to benefit clients; sufficient time and training is provided to allow therapists to learn about research techniques and results; and their professional autonomy is respected. Research is a bad or threatening presence if it is used as a strategy for managerial control rather than client benefit, or if it merely adds to the stress of the job.

In a thoughtful review of these issues, Midgley (2009) suggested that, in relation to their attitudes to Evidence Based Practice (EBP), therapists could be broadly divided into two groups – disseminators and revisionists:

*disseminators* broadly support the aims and goals of the EBP movement and wish to see it impacting on practice, whether in the fields of medicine, health or social care more broadly. But they are aware of the fact that this does not always happen successfully. For the disseminators, the primary issue is that of the better *translation* of research findings in the practice setting. (Midgley, 2009: 31)

*Revisionists* are not content simply to look at ‘obstacles’ and ‘drivers’ to implementation, but suggest that there are more fundamental reasons why EBP does not translate into practice very successfully. While the revisionists support the fundamental principle of improving practice through the systematic use of evidence, they argue for a re-visioning of – a looking again at – the whole relationship between research and practice, in order to develop a more meaningful form of EBP. One of the most common points made by the revisionists is that the very definition of

‘evidence’ being used in EBP is far too restrictive, with a high value put on ‘context free’, ‘scientific’ evidence (exemplified by the RCT), in which the internal validity of the research design itself is given priority over the external validity of the findings. The revisionists have often taken issue with the types of research design usually prioritised by the EBP movement, arguing that smaller-scale, qualitative research needs to be given greater prominence (Midgley, 2009: 31).

The following chapter looks at some of the arenas in which the debate between revisionists and disseminators has been pursued. What we will see is that it is the disseminators who have made the running, in terms of initiating a wide range of strategies for translating research findings into clinical practice. Then, Chapters 3–5 offer a broadly revisionist manifesto that re-envisages some of the ways in which the relationship between research and practice can be understood.

