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What Findings Do Psychotherapy Researchers Use in Their Own Practice? A Survey of the Society for Psychotherapy Research

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Abstract ~ Over the past decades, both clinical researchers and practitioners alike have noted the gap between psychotherapy research and practice. Previous research has found that a contributing factor to this gap is that psychotherapy research lacks ecological validity. Therefore, in an effort to distinguish research findings that do have an impact on clinical practice, the present study investigates the following primary question: what particular research findings do psychotherapy researchers, who are also clinical practitioners themselves, find to be useful within their

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own clinical practice? Since members of the Society for Psychotherapy Research (SPR) are comprised of psychotherapy research-practitioners, they were asked to fill out a web-based Psychotherapy Research Questionnaire (PRQ) that would help answer this question.

Introduction

Over the past several decades, psychotherapy researchers have asserted that a major goal of psychotherapy research should be the dissemination of information that readily shapes how clinicians treat clients within their own clinical practice-that is, research should have an ecologically valid framework. However, the consensus among clinical practitioners is that research within the field has been bereft of such a framework resulting in a chasm between actual research and practice, i.e., the research-practice gap (e.g., Barlow, 1981; Elliot, 1983; Fiske et al., 1970; Gelso, 1979; Goldfried, 2000; Goldfried, Borkovec, Clarkin, Johnson, & Parry, 1999; Goldfried & Wolfe, 1998; Kogan, 1963; Sobell, 1996; Strupp, 1968, 1981; Strupp & Bergin, 1969; Williams & Irving, 1999; Wolfe, 1994). Literature on psychotherapy research methodology has proffered several specific reasons as to why the research-practice gap exists:

(1) Variables (such as populations, manualized treatments, and assessment measures) do not truly capture what occurs in therapy (Ablon & Marci, 2004; Goldfried & Eubanks-Carter, 2004; Morrow-Bradley & Elliot, 1986; Westen, Novotny, Thompson-Brenner, 2004).

(2) The methodologies used to conduct psychotherapy research are not well selected or described (Morrow-Bradley & Elliot, 1986; Westen et al., 2004).

(3) The existence of language barriers: research is not

being communicated in ways that could be readily understood and applied by therapists, as well as the differences in vernacular between theoretical disciplines to describe the same or similar phenomena (Goldfried, 2000; Morrow-Bradley & Elliot, 1986).

Basic, Process and Outcome Research

In order to delve deeper into the factors that contribute to the divide between research and practice, it is of value to describe the three primary, and distinct, types of research that hold implications for clinical practice; namely, basic research, process research and outcome research (Arkowitz, 1989; Goldfried & Eubanks-Carter, 2004; Goldfried & Wolfe, 1996).

As suggested by Arkowitz (1989) basic research provides therapists with information regarding what needs to be changed. In particular, it provides information regarding the types of problems patients may present in therapy and areas that would be beneficial to target within therapy (cited in Goldfried, 2000). For example, basic laboratory research has found individual differences in cognitive style between individuals with and without a history of depression; insomuch that individuals who exhibit higher degrees of ruminative self-focus have an increased risk of depression relapse (Watkins & Teasdale, 2001; Watkins, Teasdale & Williams, 2000). These findings have led to the development of mindfulness-based cognitive behavioral therapy, which is designed to teach patients in remission from recurrent major depression to become more aware of their mental states within the here-and-now. In other words, by focusing patients on the dynamics occurring within their present and surrounding environment (e.g., the present inter-personal dynamics between the therapist and the patient), the therapist can teach the patient how to become aware of, and relate differently to, automatic and rumi-

native patterns of self-thought, particularly when negatively-charged, that would lead the patient to depression relapse (Teasdale, 2004). Thus, basic research helps to shed light on what needs to be addressed in therapy with this particular population.

Process research clarifies how change occurs within therapy, by closely investigating the factors within therapy that have the greatest impact on the patient. As noted by Goldfried and Eubanks-Carter (2004), although process research can have some underlying theoretical assumptions, it is a more empirically-driven approach to investigating the specific in-session occurrences that contribute to therapeutic change (Greenberg & Pinsof, 1986, as cited in Goldfried & Eubanks-Carter, 2004). Furthermore, "[i]n contrast to using the final outcome of therapy after termination-'big-O' process research seeks to determine the immediate and intermediate outcome of in-session events-'little-o'" (Greenberg, 1986, as cited in Goldfried & Eubanks-Carter, 2004).

For example, one of the most consistent findings within process research is that therapeutic alliance is one of the strongest prerequisites for change in psychotherapy (Safran, Muran, Samstag & Stevens, 2002). Bordin (1979) hypothesized that there are three components to the alliance (1) agreement on tasks, (2) agreement on goals and (3) the therapeutic bond, and that these three components influence one another throughout therapy in an ongoing fashion (Safran et al., 2002). For example, patient-therapist moment-to-moment agreement and collaboration on tasks and goals will facilitate the therapeutic bond. Conversely, having a strong therapeutic bond will facilitate the negotiation of tasks and goals (Safran et al., 2002). Furthermore, of significant importance to the negotiation of the therapeutic alliance is the identification of rupture markers (i.e., patient-therapist misunderstandings or strains to the therapeutic alliance) throughout the

therapy process that would indicate to the therapist that he/she must proceed in a therapeutically different way (Goldfried & Wolfe, 1996; Safran et al., 2002; Wallner-Samstag, Muran & Safran, 2004). Moreover, as cited by Goldfried and Wolfe (1996), process research can have important clinical implications for identifying the dynamics/determinants of clinical problems, which would help establish initial and ongoing case formulation that would subsequently allow researchers to track how individual therapists affect patients in ways that result in positive outcomes or changes in the patient's presenting problems (Goldfried, 1995).

Outcome research is distinct from basic and process research in that it specifies whether change has occurred (Goldfried & Eubanks-Carter, 2004). As is outlined by Goldfried and Wolfe (1996) and Goldfried & Eubanks-Carter (2004), outcome research has undergone many changes since the 1950s, when the first-generation of outcome research focused on whether psychotherapy effectively brought about personality change. Around the 1960s and 1970s, the emergence of second-generation outcome research was associated with behavioral therapy. The question around this time shifted from whether therapy works to how to methodologically test the procedures that work best for specific clinical problems (Franks, 1969, cited in Goldfried & Wolfe, 1996). However, Generation II outcome research was limited since student volunteers, as opposed to clinical patients, were the participants predominantly used. Beginning in the 1980s, there was a third shift in outcome research with the adoption of the medical model. During this time, outcome research became known as clinical trials or randomized control trials (RCT), terminologies associated with drug studies, and target problems were replaced with DSM diagnoses (Goldfried & Wolfe, 1996, 1998). This change was precipitated by pressure from the National Institute of Mental Health (NIMH) Treatment of Depression Collaborative Research Program (Elkin, Parlof,

Hadley & Autry, 1985), and from the Congress to contain the rising costs of mental health care, particularly through Medicaid and Medicare. As described by Goldfried and Wolfe (1998):

> With the increasing influence of psychiatry at the NIMH and the fact that drug therapies were providing convincing evidence of symptomatic benefits for a number of specific disorders, the clinical trial eventually was ratified as the standard means by which efficacy of any treatment would be evaluated. A decision was made by the NIMH, the leading source of research funds for psychotherapy research, that the same standards used in pharmacotherapy research would be applied to the evaluation of the psychotherapies.

Thus, Generation III, or the clinical trial era (still current to this day), shifted the focus of research to the use of clinical populations in combination with specific treatment manuals (referred to herein as evidence-supported therapies) for the reduction of symptoms of specific DSM-defined mental disorders, and to the use of measures of therapist adherence to these evidence-supported therapies (Goldfried, 1996, 1998; Goldfried & Eubanks-Carter, 2004).

The Research-Practice Gap

Although the shift to evidence-supported therapies seen within Generation III has increased the internal validity of outcome research, many researchers have also noted that it has done so at the expense of external validity - the applicability of research findings to actual clinical practice (Goldfried & Wolfe, 1996, 1998; Westen et al., 2004). This lack of external validity has been attributed by Westen et al. (2004) to the assumptions that underlie RCT methodology. In particular, the assumptions that psychopathologies are malleable and that the same fixed number of

sessions can be utilized across psychopathologies (the usual range being from 6-16 sessions), that patients can be treated for a single clinical disorder in isolation, disregarding the possible influence of certain associated personality disorders, and that experimental methods provide the gold standard for identifying useful psychotherapeutic packages. However, these assumptions differ from what is actually witnessed within clinical practice. For example, Seligman (1995) found that individuals who stay in therapy longer than six months reported more improvement in symptoms than those individuals who attended therapy for less time. Westen et al., (2004) also point out that within clinical practice, patients with only one diagnosis (patients that are "symptomatically pure") are the exceptions, rather than the rule.

Where Do We Go From Here?

In order to know the directions future psychotherapy research should take in order to help fuse the gap between research and practice; it would be of great worth to start by investigating the research findings that psychotherapy researchers themselves find useful in informing their clinical practice. Morrow-Bradley and Elliott (1986) had previously conducted a survey of APA Division 29 (Division of Psychotherapy) where it was found that both psychodynamically- and behaviorally-oriented therapists generally showed more interest in process/process-outcome research than basic or outcome/clinical trials research, although behaviorally-oriented therapists specifically demonstrated less interest in therapeutic alliance research than did psychodynamically-oriented therapists. The participants that comprised Morrow-Bradley and Elliott's (1986) study were therapists who did and did not actively participate in psychotherapy research. However, the present study is specifically interested in surveying psychotherapy researchers who are also practicing clinicians. Since these professionals actively take part in both sides of the research-practice divide, their experiences would be of great

importance to the efforts in fusing said divide. Furthermore, a pivotal question within the current study is: what psychotherapy research findings have psychotherapy researchers themselves found to be most useful and informative to clinical practice? The current research seeks to answer this question, by surveying members of the Society for Psychotherapy Research.

Method

Participants

Members of the Society for Psychotherapy Research (SPR) were asked to fill out an anonymous web-based Psychotherapy Research Questionnaire (PRQ). Members of SPR were selected because they represent a group of practicing therapists who have had extensive exposure to research in psychotherapy.

Measure

The PRQ, which combines both qualitative and quantitative methodologies, underwent four separate iterations to remove redundant items, to add new items or to reword existing items and instructions for greater clarity. Graduate students and clinical faculty within the New School clinical program carried out the review process. The quantitative aspect of the questionnaire was, in part, based on the questionnaire used by Morrow-Bradley and Elliott (1986).

Procedure

The survey was administered and mostly constructed according to the guidelines suggested by Alreck and Settle (1994), Couper (2001), Couper, Traugott and Lamias (2001), and by Tourangeau (2004). Additionally, a web-survey company named "Zoomerang" was used as the survey website host for the PRQ. Initially, members of SPR were contacted via email and invited to participate in a web-based survey. Within the email they were informed that the questionnaire was completely anonymous and

for that reason a universal link was included that would anonymously lead them to the survey website. Upon entering the survey website, and before proceeding to the questionnaire, the participants were informed of confidentiality and their rights. After a period of a month, members of SPR were given reminder notices, once again via email, requesting that they please fill out the survey if they had not already done so.

Results

Return Rate

Members of the Society for Psychotherapy Research (SPR) were invited via email to visit the PRQ survey website. Two hundred and fifty-one visits from members of SPR were recorded. Members of SPR completed a total of 126 surveys for a return rate of 50.2 %.

Sample Characteristics

Respondents between the ages of 26-35 accounted for 25%, ages 36-45 accounted for 19%, and ages 46-55 for 26%, all together representing 70% of the entire sample. Males accounted for 58% of the respondents. A large majority of the sample had PhD degrees (71%). Theoretical orientation of the respondents was predominantly psychodynamic in nature (38%). A large proportion of the sample indicated that their current employment setting was academic in nature (69%).

Preliminary Quantitative Analyses

Respondents that indicated that psychotherapy research had an important impact on their clinical practice were more likely to endorse statements reflecting the importance of quantitative (r = .79, n = 122, $p < .01$) and qualitative data (r = .24, $p < .01$) within their clinical practice. The value of clinical/theoretical publications or presentations within psychotherapy research and the act of conducting psychotherapy research also showed strong

correlations ($r = .40$, $r = .36$, $p < .01$) with respondents that stated psychotherapy research played an important role within their clinical practice. These respondents were also more optimistic about the future of psychotherapy research, albeit a modest correlation ($r = .21$, $p < .05$). Respondents that endorsed ongoing experiences with clients as a major factor within their clinical practice placed more value on qualitative research ($r = .19$, $p < .05$), the experience of being a client themselves ($r = .28$, $p < .01$), and supervision or consultation with others ($r = .31$, $p < .01$). Respondents that endorsed research publications or presentations as an important factor within their clinical practice were, as expected, more likely to rate psychotherapy research as being a significant factor within their clinical practice ($r = .40$, $p < .01$); they also rated quantitative research as being valuable within their practice ($r = .40$, $p < .01$), and were more optimistic about the future of psychotherapy research as a whole ($r = .28$, $p < .01$).

PRQ Survey Percentages on Endorsed Items

The first item on the Psychotherapy Research Questionnaire asked respondents to agree or disagree with the following statement: "Psychotherapy research has had an important impact on my clinical practice." The respondents answered: strongly disagree (scale point 1; 2%), disagree (point 2; 8%), neutral (point 3; 6%), agree (point 4, 46%), and strongly agree (point 5, 39%).

The second statement was worded as "Quantitative research has had an important impact on my clinical practice" and was rated as above. The respondents answered: strongly disagree (scale point 1; 7%), disagree (point 2; 13%), neutral (point 3; 8%), agree (point 4, 45%), and strongly agree (point 5, 27%).

The third statement was as follows: "Qualitative research has had an important impact on my clinical practice." The respondents answered: strongly disagree (scale point 1; 3%), disagree (point

2; 11%), neutral (point 3; 19%), agree (point 4, 44%), and strongly agree (point 5, 24%).

Table 1. The relevance of sources of information within the clinical practice: percentages presented

Information Source	Most Helpful	Unhelpful
1. Ongoing experience w/clients	86%	1%
2. Theoretical Publications/presentations	43%	1%
3. Research publications/presentations	29%	2%
4. Experience of being a client	44%	3%
5. Supervision/consultation w/others	70%	0%
6. Conducting psychotherapy research	47%	0%

Percentage of respondents who ranked the usefulness of each source, $n = 122$

The respondents were also asked: "How optimistic are you about the future of psychotherapy research and its impact on clinical practice?" They responded: strongly pessimistic (scale point 1; 1%), somewhat pessimistic (point 2; 9%), neutral (point 3; 6%), somewhat optimistic (point 4, 55%), and strongly optimistic (point 5, 29%). Overall, 84% of the sample was optimistic about the impact psychotherapy research would have on clinical practice.

Preliminary Qualitative Analysis

Presented here are some of the most mentioned, or noteworthy, answers provided for the qualitative aspects of the Psychotherapy Research Questionnaire (For question 12, n=109; question 13, n=99; question 14, n=70; question 15, n=28; question 16, n=103).

Question 12: Please give 2 or 3 specific examples of research findings that have has a significant impact on your clinical practice.

> "Findings about the therapeutic alliance/alliance ruptures"
>
> "Efficacy of exposure-based treatments for anxiety"
>
> "Effectiveness of Cognitive Behavioral Therapy and Dialectical Behavioral Therapy"

Question 13: Please elaborate on how, or in what ways, each of the specific research findings mentioned above has had an impact on your clinical practice.

> "I am trying to identify and encourage patients' resources instead of only focusing on problems; I am trying to establish a warm relationship instead of trying to appear only professional; I choose an integrative approach to therapy instead of using only one approach"
>
> "Companies convinced by CBT research tout empirically-validated technique, justify restricted payments and time, mandate mechanical approaches, disparage alternatives. As a clinician and as a clinical supervisor I witness clinicians bucking against these pressures, yet also being considerably influenced by them, barely able to articulate alternatives. Especially in stressful situations, such as concern about client safety, I see clinicians rush to liability-reducing protocols which risk subjecting ct's to approaches which prioritize clinician and agency agendas over the therapeutic relation and other relational approaches that might actually decrease the likelihood of engaging in self-harm without increasing alienation,

damaging the therapeutic relationship, or threatening to restrict their autonomy. Information about writing and exercise has been helpful for working with clients, esp. those who seek to manage their mental health without medical intervention."

"As a psychodynamic counselor, I am much more influenced in the consulting room by theory, training, supervision, etc. This is partly because of the relative lack of research on p-dynamic therapy compared to other kinds, and because of the preponderance of studies comparing different types of therapy."

Question 14: If you have not already done do, please list specific research publications that have had an impact on your clinical practice.

"Safran's work on the therapeutic alliance"

"Foa et al., Kernberg, Clarkin et al., Luborsky, Linehan, Fonagy et al."

"DeRubeis & Chamblass' 1998 article on ESTs"

Question 15: If you have not already answered this in question 13; please elaborate on how, or in what ways, each of the specific research publications mentioned have had an impact on your clinical practice.

"DBT studies encouraged me to train in this modality. Alliance literature reminds me 'where the money is'. Attachment literature provides a system for understanding how we all organize our experience, and how I as a clinician can gain insight into my clients' functioning by observing how they express themselves, in addition to

the content of their expression (centrality of process, limited utility of content)."

"Allowed me to pay more attention to the importance of the relationship and in the idea that not all moments in therapy have the same impact.."

"I mostly look for review or summary articles about what is known about using a particular approach or dealing with a particular problem or issue. The truth is I guess on the whole I get more from books than articles. But I do scan journals for interesting articles."

Question 16: What are the most important questions that still need to be answered in psychotherapy research?

"Research has shown that certain aspects of therapy, regardless of clinician orientation promote positive outcomes. What kinds of trainings for clinicians can best promote the development of clinicians capable of embodying these qualities and completing these tasks with clients?"

"We need a paradigm shift in which we focus less on outcomes at the level of the therapy and more on outcomes at the level of distinct processes. More pragmatic for practice purposes and less divisive in terms of orientations - as it is unclear how similar or dissimilar orientations often are anyway within a given process, I believe (and as meta-analyses bear out) that orientation is a poor independent variable."

"We urge consideration of what works with whom, under what conditions."

Discussion

Analysis of available qualitative and quantitative data reveals emerging trends. For the most part, irrespective of psychotherapy research, what psychotherapy researchers themselves have found most useful within their clinical practice is both their ongoing experience with clients and their supervision and consultation with others. Additionally, there appears to be a greater interest on process research, in particular research on the therapeutic alliance and ruptures. Additionally, many researchers have mentioned Linehan's work with Dialectical Behavior Therapy and have expressed an interest in attachment theory, as well as an integrative approach to psychotherapy. Although these analyses are preliminary, particularly as regards the qualitative aspects of the questionnaire, from what we can note thus far, we expect that the data will show strong trends, particularly towards the focus on process research as it relates to outcome.

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