CLINICAL PSYCHOLOGY
SCIENCE AND PRACTICE

Does Psychotherapy Research Influence the Clinical Practice of Researcher–Clinicians?

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This survey evaluated the impact of empirical research findings on the clinical practice of a sample of psychotherapists who are also actively engaged in the consumption, critical evaluation, and production of psychotherapy research. On the one hand, we found that even this sample of researcher–clinicians perceives empirical research to be less helpful to them as clinicians than a variety of other sources of information, including their ongoing experience working with clients. On the other, we found that they do value empirical research, but consider it as one source of information among others to be incorporated into the clinical decision-making process. Implications of the findings are discussed with respect to a number of dimensions, including the nature of professional expertise.

Key words: **professional expertise, research and practice, research–practice gap, research utilization.** ***[Clin Psychol Sci Prac 18: 357–371, 2011]***

Over the past several decades, a large literature has accumulated demonstrating that psychotherapy of various types is an effective treatment for a range of psychological disorders (Lambert & Ogles, 2004; Lipsey & Wilson, 1993; Smith, Glass, & Miller, 1980). At the same time, research has consistently shown that practicing clinicians do not find psychotherapy research to be particularly relevant to clinical practice. Morrow-Bradley and Elliott (1986) conducted one of the earliest and most widely cited surveys examining the degree to which clinicians utilize the findings of psychotherapy research in their practices. They surveyed members of the American Psychological Association's (APA) Division of Psychotherapy (Division 29) and found that a marginal percentage (10%) of a total of 279 therapists reported that psychotherapy research articles or presentations were their primary source of guidance as clinicians. The most highly ranked sources of information were "ongoing experience with clients" (48%), followed by "theoretical publications and presentations" (17%). Morrow-Bradley and Elliott (1986) also asked their sample to rate the usefulness of seven different therapy research areas (e.g., outcome research that compares a treatment with a control group and/or other treatment approaches, process-outcome research that links the process of therapy to differential outcomes). They found that the research areas endorsed as most useful focused on topics such as the *process of change* and the *therapeutic alliance*. Their respondents expressed less interest in research comparing the outcomes of different forms of psychotherapy or in studies evaluating the effectiveness of a specific form of therapy relative to a control group.

In that same year, Cohen, Sargent, and Sechrest (1986) conducted in-depth interviews with 30 practicing clinicians and found that empirical research received the lowest clinical usefulness ratings of a number of different information sources, including discussions with clinical colleagues, workshops on clinical practice, theoretical books on clinical practice, and both how-to books and articles on clinical practice. Since that time, numerous studies using a variety of

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methodologies have continued to find that clinicians perceive psychotherapy research as having limited relevance to their clinical practices (e.g., Beutler, Williams, Wakefield, & Entwistle, 1995; Lucock, Hall, & Noble, 2006; Mussell et al., 2000; Nunez, Poole, & Memon, 2003). In a more recent study, Stewart and Chambless (2007) surveyed APA's Division of Independent Practice (Division 42). They found that respondents rated their own clinical experience as significantly more relevant to making typical treatment decisions than either current research on treatment outcome, experiences in personal therapy, or colleagues' advice.

This continuing evidence of a gap between research and practice has been the topic of countless publications over the years that bemoan its existence and suggest various alternative solutions (e.g., Bergin & Strupp, 1972; Goldfried & Wolfe, 1996, 1998; Persons & Silberschatz, 1998; Rice & Greenberg, 1984; Safran, Greenberg, & Rice, 1988; Safran & Muran, 1994; Westen, Novotny, & Thompson-Brenner, 2004). It has also been a source of frustration for researchers. For example, a widely cited article by Baker, McFall, and Shoham (2009) compares clinical psychology to the prescientific state of American medicine at the time of the Flexner report in the early 20th century. Citing evidence indicating that many clinicians give more weight to their personal experiences than to science in making decisions about intervention, Baker et al. (2009) argue that "although it is patent that impressionistic, clinical judgments are prey to numerous biases…clinicians continue to use the former and eschew the latter." In this vein, they continue, "The upshot is that the person seeking psychological services from a clinical psychologist cannot assume that his or her treatment will be informed by the fruits of the inferential deductive discipline known as science" (p. 83).

From Baker and colleagues' (2009, p. 83) perspective, many practicing clinicians display what the authors regard as an "insouciance" in the face of the strong evidence base for the efficacy and cost-effectiveness of specific forms of therapy. According to them, this is harming the field and marginalizing clinical psychology within the health care system. To solve this problem, Baker et al. (2009) advocate for the more widespread acceptance of an alternative to the current APA accreditation system, recently launched by the Academy of Clinical Science, which only accredits clinical programs that are considered "science based" in nature.

In contrast to Baker and colleagues' (2009) perspective, various critics over the years have raised questions about the relevance of much existing psychotherapy research to clinicians. Many criticisms fall into the general category of poor external validity. Critics argue that randomized clinical trials (RCTs), which have become the "gold standard" of psychotherapy research, have limited clinical relevance for a number of reasons. They point out, for example, that RCTs have limited external validity because patients are randomly assigned to treatments rather than choosing their own therapists (e.g., Seligman, 1995). Critics also argue that the types of patients typically seen in real-world practice are often screened out of RCTs because of comorbid diagnoses. Moreover, they argue, clinicians in real-world practice find manualized treatments too inflexible, feel that both treatment lengths and follow-up intervals are too short in RCTs, and find that RCTs often fail to capture change in ways that are clinically meaningful (Goldfried & Wolfe, 1996, 1998; Persons & Silberschatz, 1998; Westen et al., 2004). Other critiques focus on issues such as the lack of relevance of RCTs for the clinician who is confronted with the question of how to intervene with a specific patient in a particular moment (e.g., Greenberg, 1984, 1986; Rice & Greenberg, 1984; Safran & Muran, 1994; Safran et al., 1988).

Over the years, attempts to develop research approaches that are more relevant to the practicing clinician have led to the development and implementation of a variety of different alternatives. These include systematic, research-informed case study approaches (Fishman, 1999; Strupp, 2001); a focus on the mechanisms of change (Gendlin, 1986; Greenberg, 1986; Rice & Greenberg, 1984; Safran & Muran,1994; Safran et al., 1988), qualitative research methods (e.g., Elliott, 1984; Hill et al., 2005; Rennie, Phillips, & Quartaro, 1988; Stiles, 1993); and approaches such as task analysis, which integrate qualitative and quantitative research methods (e.g., Greenberg, 1986; Rice & Greenberg, 1984).

Advocates for the use of these methods argue that clinical trials that use group data to test hypotheses about the effectiveness of different forms of therapy fail to

capture the complexity and subtle nuances of clinical process and tend to emphasize *hypothesis* testing at the expense of the *discovery-oriented* aspects of research (e.g., Elliott, 1984; Greenberg, 1986; Hill et al., 2005; Rennie et al., 1988; Stiles, 1993). They also argue that qualitative methods and approaches that incorporate qualitative methods can make use of the researcher's capacity for rigorously observing the process of change, or what Rice and Greenberg (1984) have referred to as *patterns of change that recur across multiple cases*, and therefore the opportunity for *discovery* of phenomena that are not already known (e.g., Elliott, 1984; Greenberg, 1986; Hill et al., 2005; Rennie et al., 1988; Stiles, 1993).

RATIONALE FOR THIS SURVEY

Most surveys on psychotherapy research utilization have been conducted with therapists whose professional time is heavily devoted to the practice of psychotherapy, and who are not actively engaged in reading and critically evaluating the psychotherapy research literature or conducting research themselves. For example, 82% of Morrow-Bradley and Elliott's (1986) sample reported spending more time in practicing, supervising, or consulting about psychotherapy than in any other professional activity. Seventy-three percent were employed in private practice or other primarily clinical settings, with only 19% working in university or medical school settings. Modal number of research articles read in the last month, research conferences attended in the last year, and total number of research publications or presentations produced were all 0. Sixty-two percent reported not conducting any research. Stewart and Chambless (2007) did not ask their sample to indicate how much research they read or produced, but 88% of their sample identified private practice as their primary employment site. It seems reasonable to infer that like many full-time clinicians, respondents in these surveys do not work in environments that encourage an ongoing interest in research, nor are they likely to be familiar with the latest developments in psychotherapy research. Moreover, they are not immersed in professional cultures that place a high value on psychotherapy research.

We wondered if clinicians who are more immersed in a psychotherapy research culture might have different attitudes regarding the clinical utility of psychotherapy research than the average clinician. The objective of this study was thus to survey respondents who are actively involved *both* as clinicians *and* as psychotherapy researchers. We were interested in the question of whether such respondents would be more likely than their less research-oriented colleagues to see research as clinically relevant. We also wondered if a sample of clinician–researchers who are particularly likely to be familiar with some of the recent developments in psychotherapy research described earlier would be more likely to find research to be clinically useful.

For these reasons, we decided to survey members of the Society for Psychotherapy Research (SPR). Founded in 1969 as an international multidisciplinary scientific organization, SPR has from its inception emphasized the importance of integrating research and practice (Orlinsky, 1995). There is a long-standing tradition of SPR members being actively involved *both* as researchers and consumers of research *and* as practicing clinicians themselves (Angus et al., 2010). Members of SPR have played a significant role in developing alternative research approaches designed to produce findings that are more meaningful to the clinician and in conducting this type of research themselves (see, e.g., the recently published collection of essays about prominent SPR members, *Bringing Psychotherapy Research to Life: Understanding Change Through the Work of Leading Clinical Researchers*; Castonguay et al., 2010). Moreover, *Psychotherapy Research,* the official SPR journal, is an important publication outlet for research that has been influenced by methodological innovations designed to increase the clinical utility of psychotherapy research. Finally, in contrast to most samples previously surveyed on the topic of research utilization, SPR is an international organization. Surveying members of SPR would thus allow us to examine the attitudes of researcher–clinicians who are more representative of the international community than has been the case with many psychotherapy research utilization surveys.

METHOD

Participants, Procedure, and Survey

All members of the Society for Psychotherapy Research (SPR) were contacted via e-mail and invited

to participate in a web-based survey. Within the e-mail, participants were informed that the questionnaire was anonymous and were provided with a universal link that would securely lead them to the survey web site. Upon entering the survey web site, but before proceeding to the questionnaire, the participants were informed of their confidentiality and rights. After a period of a month, members of SPR were e-mailed participation reminder notices.

There were two sections to our survey: quantitative and qualitative. The first section consisted of a series of items rated on 5-point rating scales. Respondents were first asked to rate the impact of psychotherapy research (in general) on their clinical practices. They were then asked to rate the impact of quantitative research on their clinical practices. This was followed by a question asking them to rate the clinical impact of qualitative research. We were interested in having respondents distinguish between the clinical impact of quantitative versus qualitative research, given the arguments that have been advanced regarding the incremental clinical utility of qualitative research over quantitative research, and the marked upswing in the use of qualitative research methods by psychotherapy researchers over the last three decades (Hoyt & Bhati, 2007; Rennie, Watson, & Montiero, 2002). Next, we asked respondents to rate the degree of their optimism about the field of psychotherapy research. Finally, we asked them to rate the relative impact of various sources of information on their clinical practices (e.g., psychotherapy research, theoretical publications, personal experience working with patients, and clinical supervision).

The second section of our survey was designed to shed additional light on the types of research findings that these researcher–clinicians find most relevant to their clinical work by eliciting responses to the following open-ended question: ''Give two or three examples of research findings that have had a significant impact on your clinical practice.'' Our hope was that this open-ended question might yield a richer, more nuanced picture of the types of research that our respondents find useful, rather than asking them to rate pre-established categories in the way that Morrow-Bradley and Elliott (1986) had done. We reasoned that this might be particularly valuable, especially given the innovations in psychotherapy research methodology that have become well established since the mid-1980s.

RESULTS

Return Rate and Sample Characteristics

One thousand and sixty-six members (the total membership list of SPR at the time) were e-mailed regarding the online survey. A total of 250 web site visits were recorded (23%) and 123 responses (12%) were received. Respondents within the age range of 26–35 accounted for 26% of the sample, ages 36–45 accounted for 19%, ages 46–55 for 24%, and ages 56–65 for 22%. The remaining 9% of the sample fell outside of these age ranges. Men accounted for 56% of respondents and 44% were women. The majority (68%) of our sample had PhD degrees. Less than 11% of respondents had a degree in social work, licensed clinical social work, or were in graduate school in pursuit of a professional degree.

The majority (60%) of our respondents were employed either exclusively in an academic setting or in an academic setting and at least one additional setting (e.g., hospital, clinic, or private practice). On this dimension, our sample stands in clear contrast to the sample of APA Division 29 members that was surveyed by Morrow-Bradley and Elliott (1986), where the majority were employed in private practice settings (61%). Only 8% of the current sample was employed exclusively in a private practice setting, with an additional 12% employed at least part time in private practice. In addition, over 82% of the current sample reported having conducted psychotherapy research for over 5 years, and almost half (47%) reported conducting research for more than 15 years. In contrast, the majority of Morrow-Bradley and Elliott's (1986) sample reported considerably less involvement in research, with 62% reporting not conducting any research.

With respect to clinical practice, 82% of the current sample reported having 6 or more years of clinical experience, and 66% reported practicing as clinicians for 11 or more years. Sixty-eight percent of the current sample reported spending six or more hours per week in clinical practice, and only 1.7% reported not currently practicing as clinicians The demographic data thus provide clear evidence that respondents in our current sample were active as both clinicians and

psychotherapy researchers, and this distinguishes them from those respondents usually surveyed in clinical utilization studies, who tend to fall more toward the clinician end of the scientist-practitioner spectrum (e.g., Beutler et al., 1995; Cohen et al., 1986; Lucock et al., 2006; Morrow-Bradley & Elliott, 1986; Mussell et al., 2000; Stewart & Chambless, 2007).

Respondents represented a wide range of theoretical orientations, with psychodynamic being the most commonly endorsed (35%). Ten percent designated themselves as cognitive-behavioral, 27% designated themselves as being either eclectic or integrative, 15% designated themselves as humanistic, and 13% designated themselves as ''other.'' On this dimension, there were both similarities and differences between our sample and Morrow-Bradley and Elliott's (1986) sample, in which 20% designated themselves as cognitive-behavioral, 36% designated themselves as eclectic, 36% psychodynamic, and 8% ''other.''[1]

Finally, in contrast to many research utilization studies that have been published, approximately 40% of our sample came from countries outside of North America. Over 20 different countries were represented in our sample. Almost 60% of respondents came from North America—United States (52%), Canada (7.3%)—with approximately 40% of the sample representing 20 different countries in Europe and Latin America. The following five countries were most highly represented in our sample: United States (52%), Canada (7.3%), Italy (4.9%), United Kingdom (4.1%), and Sweden (4.1%.)

Because our return rate (12%) was relatively low, questions arise as to the sample's representativeness of the larger SPR membership on important characteristics. As we were not able to find data of this type, we conducted a second web site survey of the SPR membership to obtain it. To maximize responsiveness, completion time for this survey was designed to be extremely brief (2–3 min maximum). This brief survey was e-mailed to everyone on the SPR membership list at the time (a total of 1,173 members). This time we obtained a return rate of 73%, which is considered acceptable (Dillman, 2006).

The distribution of sample respondents from our research utilization survey within each of the relevant characteristic categories (e.g., age, gender, work setting, years of involvement as researchers, years of clinical experience, and total hours of clinical practice per week) was then compared to the distribution of the larger sample with respect to these characteristics. As we could not assume independence of the two samples, we treated the data obtained from our brief survey of membership characteristics (the second survey) as our best estimate of the population (the SPR membership as a whole). We then calculated confidence intervals for proportions for respondent characteristics in our first survey and evaluated the extent to which the values obtained in our second survey were included in the relevant confidence intervals for the first (Brown, Cai, & Dasgupta, 2001; Clopper & Pearson, 1934). The confidence level was set at 95% (i.e., $p < .05$). The only significant differences that emerged were on the characteristics of age (where we appear to have undersampled members in the 66–75 years category), years of clinical experience (where we undersampled the more than 30 years category), clinical hours per week (where we undersampled the 11–15 hour category), and theoretical orientation (where we undersampled psychodynamically oriented clinicians and oversampled those designating themselves as eclectic). We thus have some evidence regarding our survey sample's representativeness of the larger SPR membership.

Questions and Rating Endorsement Percentages

The first survey item asked respondents to agree or disagree with the following statement: ''Psychotherapy research has had an important impact on my clinical practice.'' The respondents answered accordingly: strongly disagree (scale point 1: 2%), disagree (scale point 2: 7%), neutral (scale point 3: 7%), agree (scale point 4: 45%), and strongly agree (scale point 5: 39%). As a reference point, Table 1 compares the current sample's response to this question to the Morrow-Bradley and Elliott (1986) sample's response to a similar question.

It should be noted that Morrow-Bradley and Elliott (1986) phrased their question slightly differently (i.e., ''Please rate the extent to which the results from psychotherapy research influence your clinical practice''), used a 6-point rating scale, and used different anchor points (see Table 1). These differences make it somewhat difficult to directly compare the responses of the

Table 1. Impact of research on clinical practice

Scale Point	This Survey Research has had an important impact on my clinical practice (%)		Morrow-Bradley & Elliott, 1986 The extent to which research has had an impact on your practice (%)	
1	Strongly disagree	2	Not at all	5
2	Disagree	7	Minimally	26
3	Neutral	7	Some	42
4	Agree	45	Quite a bit	17
5	Strongly agree	39	A great deal	10
6	[a]	N/A	More than any other factor	0

[a]This survey used a 5-point scale.

two samples. For example, the fact that the anchor for scale point 6 in Morrow-Bradley and Elliott's (1986) study was ''more than any other factor'' likely accounts for the absence of any endorsement by raters, and there is no way of knowing how the respondents in our sample would have responded to this scale point and anchor. Nevertheless, an examination of Table 1 suggests that substantially more respondents in the current sample endorsed rating points toward the ''more impactful'' end of the scale than in the Morrow-Bradley and Elliott (1986) survey. For example, if we treat Morrow-Bradley and Elliott's scale as a 5-point rating system by leaving out the scale point with the anchor ''more than any other factor'' (as there is no comparable anchor on our scale), we can see that considerably more respondents in our sample still endorsed the top two scale points (i.e., more impactful) than in the Morrow-Bradley and Elliott (1986) sample (84% vs. 27%). Moreover, substantially fewer respondents in the current sample endorsed the bottom two scale points (i.e., less impactful) than in the Morrow-Bradley and Elliott (1986) survey (9% vs. 31%).

The second item was worded as follows: ''Quantitative research has had an important impact on my clinical practice.'' Once again respondents were instructed to rate this statement on a 5-point scale, using the same anchors as in the previous question. The respondents answered strongly disagree (scale point 1: 6%), disagree (scale point 2: 13%), neutral (scale point 3: 9%), agree (scale point 4: 45%), and strongly agree (scale point 5: 27%). The third item was worded as follows: ''Qualitative research has had an important impact on my clinical practice.'' The respondents answered strongly disagree (scale point 1: 2%), disagree (scale point 2: 11%), neutral (scale point 3: 20%), agree (scale point 4: 44%), and strongly agree (scale point 5: 23%).

A paired samples *t*-test (two-tailed) failed to find significant differences in respondents' ratings of the clinical impact of quantitative versus qualitative research, $t(121) = 0.23$, $p > .05$.

The fourth item asked: ''How optimistic are you about the future of psychotherapy research and its impact on clinical practice?'' The responses were as follows: strongly pessimistic (scale point 1: 1%), somewhat pessimistic (scale point 2: 8%), neutral (scale point 3: 7%), somewhat optimistic (scale point 4: 56%), and strongly optimistic (scale point 4: 28%). Although only 28% were highly optimistic about the future of psychotherapy research overall, 84% of the sample was either ''somewhat optimistic'' or ''strongly optimistic'' about the potential impact of psychotherapy research in the future.

The fifth item asked respondents to evaluate the relative impact of various sources of information on their clinical practice. It was phrased as follows: ''Please rate the extent to which you agree about the helpfulness of the following sources of information with regard to your clinical practice.'' The respondents endorsed their assessment of the utility of the six different sources of information along a 5-point scale, with the following anchor points: 1: unhelpful; 2: somewhat helpful; 3: no opinion/neutral; 4: somewhat helpful; and 5: helpful.

Means and standard deviations of ratings for the various sources of information (listed from highest to lowest of frequency of endorsement) were as follows: ''ongoing experience with clients'' ($M = 4.78$, $SD = 0.61$), ''supervision/consultation with others'' ($M = 4.60$, $SD = 0.65$), ''conducting psychotherapy research'' ($M = 4.36$, $SD = 0.65$), ''theoretical publications and/or presentations'' ($M = 4.31$, $SD = 0.72$), ''experience of being a client'' ($M = 4.15$, $SD = 0.77$), and ''research publications and/or presentations'' ($M = 4.11$, $SD = 0.77$). To assess the extent to which significant differences in respondents' overall ratings of the helpfulness of various sources of information existed, a repeated measures ANOVA was conducted, indicating that helpfulness ratings differed significantly between information sources, Wilks's $\lambda = 0.52$, $F(5, 122) = 21.62$, $p < .001$. Post hoc tests of repeated measures *t*-tests using Bonferroni corrected *p*-value of

.003 (.05/15) indicate that respondents found both ''experience with clients'' and ''supervision and consultation'' more helpful than ''conducting psychotherapy research,'' ''theoretical publications,'' ''experience of being a client,'' and ''research publications'' (all p-values < .004). Cohen's d' effect sizes were computed, with strengths ranging from 0.89 (difference between ''experiences with clients'' and ''research publications/presentations'') to 0.39 (difference between ''supervision and consultation with others'' and ''conducting psychotherapy research'').

Table 2 provides information regarding the percentage of respondents who endorsed the two highest ends of the ratings scale (5 = helpful and 4 = somewhat helpful) and compares these findings with Morrow-Bradley and Elliott's (1986) rank-order findings.

If we restrict ourselves to examining responses to the highest scale point in our survey, we see that ''research publications/presentations'' are perceived as the least helpful source of information, whereas ''ongoing experience with clients'' is perceived as the most helpful experience. Morrow-Bradley and Elliott's (1986) sample also endorsed ''ongoing experience with clients'' as the most useful source of information. Interestingly, our sample endorsed ''conducting psychotherapy research'' as the third most helpful source of information, compared to Morrow-Bradley and Elliott's (1986) sample, which rated this activity as the least useful source of information.

When our sample's responses to the two highest scale points (''helpful'' and ''somewhat helpful'') are summed (Table 2, column 3), we see that approximately 90% of all respondents endorsed all sources of information as either ''helpful'' or ''somewhat helpful.'' Because Morrow-Bradley and Elliott (1986) only asked respondents to indicate the source of information that they found to be *most useful* to their clinical practice, caution must be exercised in comparing our results to theirs. Bearing this caveat in mind, however, we will tentatively draw some inferences regarding differences in the attitudes of the two samples in the discussion section of this article.

Theoretical Orientation and Research Utilization

As both Morrow-Bradley and Elliott (1986) and Stewart and Chambless (2007) found that psychodynamically oriented clinicians were less likely to find research to be clinically meaningful than clinicians of other orientations, we were curious whether this tendency would persist even among our sample of psychotherapy researchers. We compared the responses of psychodynamically oriented therapists (n = 44) to those of respondents identifying with all other theoretical orientations combined (n = 79) using unpaired t-tests (two-tailed). Psychodynamic therapists rated the importance of psychotherapy research with regard to their clinical practice as significantly lower than other theoretical orientations, $t(122) = 0.83$, $p < .05$. Given the evidence that psychodynamically oriented therapists tend to find research in general less relevant to their clinical practice, we were curious as to whether they might find qualitative research more relevant than quantitative research. Using an independent samples t-test (two-tailed), the relationship between theoretical orientation and the reported impact of qualitative research was explored, showing no significant differences, $t(122) = 0.25$, $p > .05$. We did, however, find that psychodynamically oriented therapists rated the relevance of ''ongoing experience with clients'' significantly higher than other therapists, $t(122) = 1.17$, $p < .05$.

Table 2. Percentage of respondents agreeing on the helpfulness of various sources of information

	This Study			Morrow-Bradley & Elliott, 1986
Information source	**Helpful**	**Somewhat helpful**	**Helpful or Somewhat helpful**	**Most Useful/Helpful**
Ongoing experience w/clients	82	11	93	48
Supervision/consultation w/others	68	24	92	7
Conducting psychotherapy research	46	44	90	3
Experience of being a client	43	53	96	8
Theoretical publications/presentations	43	53	96	17
Research publications/presentations	29	61	90	10

Qualitative Analysis

In an effort to obtain a detailed picture of which specific research findings or general types of research have had the greatest impact on respondents' clinical practices, we reviewed their answers to the following open-ended question: ''Give two or three examples of research findings that have had a significant impact on your clinical practice.'' Responses came in a number of different forms ranging from specific studies considered to be important, to lines of research associated with specific researchers, to descriptions of a particular type of research finding that has emerged consistently (e.g., ''Dodo bird verdict: most therapies are equally successful,'' ''efficacy of exposure-based treatments for anxiety,''), to general areas of research (e.g., ''attachment research,'' ''client-therapist racial matching,'' ''research on integration of therapy with drugs,'' ''affect and psychotherapy''). A total of 292 examples were provided, with an average of 2.37 examples per respondent ($SD = 0.99$). The mode and median number of examples provided were both 3. In cases where respondents gave more than one example, all examples were incorporated into the subsequent analysis.

Using a qualitative analysis procedure following general guidelines for grounded theory analysis (Charmaz, 2006; Rennie, Phillips, & Quatero, 1988; Strauss & Corbin, 1998), and also partially informed by Hill and colleagues' (2005) guidelines for consensual qualitative research (CQR), verbatim responses were carefully reviewed by the second author with the assistance of two graduate research assistants in psychology. These three acted as judges who worked as a team to rewrite the items in simplified form (when necessary), developed categories to describe thematically related items, and fit items into categories. All decisions were made by consensus procedure. This was a time-consuming, iterative process in which team members worked together to generate categories in an ongoing fashion for purposes of classifying the examples as they reviewed them. Categories were named in a preliminary fashion as they were generated. When examples could not be fit into existing categories, new categories were generated. Over time, categories that could not be used to classify five or more items were either dropped or merged with other categories that seemed sufficiently similar thematically. In addition, category names were modified as the taxonomy evolved. The senior author periodically provided input into this process when the team requested.

When members of the team agreed that the point of saturation had been reached (i.e., any new categories did not facilitate an increased understanding of the results), both the categories and the items classified within them were reviewed meticulously by an outside auditor.[2] All modifications suggested by the outside auditor were discussed with the judges, and any differences of opinion were resolved by consensus. At this point, the senior author[3] reviewed the material carefully. He proposed merging a few of the categories, some changes to category names, and reclassifying a few of the items. These proposed changes were then reviewed and approved by the original team of judges. A simple count of the number of examples belonging to each category was then conducted in an attempt to get a rough sense of the research findings most commonly reported by respondents as having a significant clinical impact. Raw frequencies were then converted into percentage of total responses provided to convey a sense of the relative importance of each of the categories from the respondents' perspectives.

Table 3 presents the 10 most common categories (as derived by the research team) of research areas or findings described in descending order of frequency of occurrence, along with three examples of each category.

''Research on the therapeutic alliance and on therapeutic alliance ruptures'' was the most commonly reported example (approximately one quarter of the examples provided by respondents were classified within this category). The second most common category was ''research on the effectiveness of various behavioral and cognitive-behavioral (CBT) interventions'' (approximately 17%). This was closely followed by examples of ''psychodynamically oriented research'' (15%). Interestingly, unlike the CBT examples reported, which focused almost exclusively on treatment outcome findings, almost all of the psychodynamically oriented examples focused on various aspects of psychodynamic process (e.g., research on countertransference, research on defense mechanisms, research on transference interpretations).

Table 3. Most common categories of research findings (with examples and approximate percentage of total)[a]

Research on the therapeutic alliance and ruptures in the therapeutic alliance (24%)	**Research on the effectiveness of behavioral and cognitive behavioral interventions (17%)**
Early alliance predicts outcome and retention	Cognitive therapy for relapse prevention in depression
Recognizing and addressing alliance ruptures	Efficacy of exposure-based treatments for anxiety
Alliance repair methods can work and improve outcome	Dialectical behavior therapy for borderlines
Psychodynamically oriented research (15%)	**Research on psychotherapy process and/or mechanisms of change (12%)**
Addressing defenses and its relation to outcome	Impact of negative therapeutic process
The potential dangers of transference interpretations	Various types of task analysis research
Research on accuracy of interpretations	Findings on client deference
Therapist or treatment intervention by patient type (7%)	**Research demonstrating therapeutic equivalence (8%)**
Family intervention and schizophrenia	The ''Dodo bird'' effect
Client–therapist racial matching	Lay therapists equally effective as trained therapists
Treatment for impoverished, depressed women	IPT and CBT equally effective for moderate depression
Attachment and developmental research (4%)	**Emotion (3%)**
Attachment research	Emotion precedes cognition
Research on reflective functioning/mentalization	Affect regulation research
Mother–infant attunement research	Experiencing level in specific contexts
Psychotherapy and medication (3%)	**Neuroscience research (3%)**
CBT has lower relapse rates for depression than antidepressants	Neurobiological impact of psychotherapy
Severe depression responds best to therapy plus medication	Brain research on amygdala and trauma
CBT performs as well as medication in various studies	Brain research on how memory functions

[a]Total is 96% because 4% of examples were not provided in sufficient number to be categorized.

The next three most common examples given were categorized as ''research on psychotherapy process or mechanisms of change'' (12%), ''research demonstrating therapeutic equivalence'' (8%), and ''research on treatment or therapist variables by patient type'' (7%). The next four types of examples reported were classified as ''attachment related and other developmental research'' (4%), ''research on emotional processes'' (3%), ''research on psychotherapy and medication'' (3%), and ''basic neuroscience research'' (3%). None of the other findings or types of research provided (4%) could be classified into categories with five or more exemplars and therefore were not classified. Examples included research on relapse prevention, Scandinavian psychosis research, dose–effect relationship research, meta-cognitive functioning in personality disorder, engagement and motivation procedures, and hermeneutic single case design research.

DISCUSSION

The major objective of this study was to find out whether a survey of clinician–researchers who are *both* actively involved in the production and critical consumption of psychotherapy research *and* the practice of psychotherapy would reveal less of a clinical-research gap than is commonly found in surveys of samples of clinicians. To this end, we surveyed members of the Society for Psychotherapy Research regarding their perceptions of the clinical utility of psychotherapy research and then asked them to contrast the impact of psychotherapy research versus other sources of information on their clinical practices. We asked our respondents to (a) rate the overall impact of psychotherapy research on their clinical work, (b) compare the impacts of quantitative versus qualitative research, (c) evaluate the relative clinical utility of a variety of different sources of information, including research, and (d) rate their overall degree of optimism about the future of psychotherapy research. We then asked them to compare the impact of psychotherapy research on their clinical work to a variety of other sources of information.

As a reference point, we compared our findings with those obtained by Morrow-Bradley and Elliott

(1986) in their sample of members of the APA Division of Psychotherapy (Division 29). As previously indicated, the two samples differed substantially with respect to employment setting and the proportion of time devoted to clinical practice versus research activity, with Morrow-Bradley and Elliott's (1986) sample more closely fitting the profile of the clinician rather than the researcher and our sample more closely fitting the profile of researcher–clinician. Over 80% of our sample reported conducting psychotherapy research for 5 years or more, and almost half reported conducting research for more than 15 years.

Despite the distinctive demographic profile of our sample, at one level the oft lamented gap between research and practice continues to be evident. Less than half (39%) of our respondents ''strongly agreed'' that psychotherapy research has had a significant impact on their clinical practices. An examination of our sample's mean ''helpfulness ratings'' of various sources of information found that both their personal experience of ''working with clients'' and ''supervision and consultation'' were rated as significantly more helpful than ''research publications.'' Similar to both Morrow-Bradley and Elliott's (1986) and Stewart and Chambless's (2007) findings, respondents in the current study were most likely to endorse their own ''ongoing work with clients'' as the source of information *most helpful* to their clinical practice. Moreover, our sample ranked ''research publications/presentations'' as the *least helpful* of the six sources of information rated. Although, as indicated earlier, the wording of the questions and the rating scale anchors in our survey were somewhat different from those employed by Morrow-Bradley and Elliott (1986), if we restrict our examination of respondents' ratings of six different sources of information to the top rating point of the 5-point ''helpfulness'' scale, it appears that our sample of researcher–clinicians was no more enthusiastic about the clinical utility of psychotherapy research findings (relative to other sources of information), and if anything less enthusiastic than Morrow-Bradley and Elliott's (1986) sample, who ranked psychotherapy research findings as more helpful than both ''supervision/consultation with others'' and ''the experience of being a client.''

Interestingly, despite the case advanced by various researchers regarding the incremental clinical utility of qualitative over quantitative research, and despite the upswing in the publication of qualitative research over the last three decades (Hoyt & Bhati, 2007; Rennie et al., 2002), the current sample reported no significant differences in their evaluation of the clinical utility of qualitative versus quantitative research. Given the degree of exposure of the SPR community to qualitative research, these findings are unlikely to be attributable to a lack of familiarity with it. One possible interpretation of these results is that more recent developments in quantitative research (e.g., change mechanism research, research-informed case studies) have increased its clinical utility, thereby ''raising the bar'' in terms of what qualitative research needs to offer to contribute added value. Even if this is the case, however, it will be important for future research to more carefully evaluate the question of whether or not qualitative methods really are delivering on their promise in the field of psychotherapy research, and if not, whether this failure is inherent to qualitative research or a reflection of the specific types of qualitative methods commonly employed by psychotherapy researchers.

As was the case in the surveys conducted by both Morrow-Bradley and Elliott (1986) and Stewart and Chambless (2007), respondents in our survey endorsing a psychodynamic orientation were less likely than clinicians of other orientations to consider research findings helpful to them in their clinical practice. This finding may be attributable to a history within the psychoanalytic tradition of dismissing the relevance of systematic empirical psychotherapy research both because of its failure to capture the complexity of the clinical process and on the basis of epistemological grounds (Hoffman, 2009; Luyten, Blatt, & Corveleyn, 2006; Safran, 2001; Safran & Aron, 2001). Interestingly, psychodynamically oriented respondents in our sample were also significantly more likely than clinicians of other orientations to find ''ongoing experience with clients'' as a helpful source of information. This may reflect the strong emphasis that psychoanalysis has traditionally placed on the pivotal role of extensive clinical experience in the training process. For example, the International Psychoanalytic Association requires trainees to complete a minimum of 4 years of supervised clinical experience prior to graduation.

If we were to focus exclusively on the various findings described above, we might simply conclude that even a sample of researcher–clinicians shows considerable skepticism about the clinical relevance of psychotherapy research. At the same time, however, it should be noted that when we examine the distribution of ratings for the question regarding the overall ''impact'' of research on clinical practice (i.e., ''research has had an important impact on my clinical practice''), we see that these ratings tend to cluster toward the top end of the scale. Moreover, when we combine ratings for the top two points of the comparative ''helpfulness'' scale (i.e., ''please rate the extent to which you agree about the helpfulness of the following sources of information to your clinical practice''), over 90% of all respondents rated psychotherapy research (as well as other sources of information) as either ''helpful'' or ''somewhat helpful'' to their clinical practice. In addition, 84% of the current sample was either somewhat optimistic or strongly optimistic about the potential impact of psychotherapy research on clinical practice in the future. Finally, when we compare SPR members' responses to Morrow-Bradley and Elliott's (1986) sample of Division 29 members' responses to the single question regarding the impact of research on their clinical practice, we find that substantially more SPR members than Division 29 members sampled by Morrow-Bradley and Elliott (1986) endorsed the top two points (''more impactful'') of the rating scale (84% vs. 27%), and substantially fewer endorsed the bottom two scale points (9% vs. 31%).

Another interesting finding was that examining the highest point on the rating scale, we see that respondents rated the activity of ''conducting psychotherapy research'' in and of itself considerably more relevant to their clinical practice than reading psychotherapy research (46% compared to 29%) and *as relevant* to their clinical practice as other sources of information, such as ''the experience of being a client'' or ''reading psychotherapy theory.'' This finding suggests that the process of conducting psychotherapy research may actually be of greater clinical value than the product of psychotherapy research. As a number of authors have indicated, the process of conducting psychotherapy research may contribute to our development as clinicians in a number of ways, including increasing our sense of humility of clinicians, and our openness to modifying our theories in an ongoing fashion (Elliott & Morrow-Bradley, 1994; Lampropoulos et al., 2002; Safran & Muran, 1994). Further exploration of the potentially valuable by-products of conducting psychotherapy research may have implications for the way in which research training is incorporated into clinical training programs. For example, placing greater emphasis on teaching students in clinical psychology programs to reflect more actively on what can be learned clinically through the process of conducting psychotherapy research may facilitate a greater degree of mutual influence between research training and clinical practice. This could potentially have a meaningful impact on clinicians' attitudes about research subsequent to graduation.

The findings that emerged from our qualitative analysis add additional texture to our understanding of this sample's attitudes toward psychotherapy research. The most commonly provided examples of influential research findings fell into the category of ''therapeutic alliance research and research on therapeutic alliance ruptures.'' This finding is consistent with the growing emphasis on the importance of the therapeutic relationship across a variety of psychotherapy traditions (Goldfried & Safran, 1986; Wolfe & Goldfried, 1988) and with initiatives such as the APA's Division of Psychotherapy Task Force on the identification of empirically supported elements of the therapeutic relationship that contribute to good therapeutic outcome (Norcross, 2002, 2011). It is also consistent with Morrow-Bradley and Elliott's (1986) findings that clinicians ranked ''research that focuses on the development and impact of the therapeutic or helping alliance'' near the top in terms of ''perceived usefulness of psychotherapy research topics.''

Another finding emerging from our qualitative analysis is that when we group together examples classified within the categories of ''research on the therapeutic alliance and ruptures in the alliance,'' ''change processes or mechanisms,'' and ''psychodynamically oriented research'' (which tended for the most part to focus on therapeutic processes or change mechanisms), we find that over 50% of the examples provided fall within the general category of ''research on psychotherapy process and change mechanisms'' rather than ''psychotherapy

outcome'' research. ''Treatment outcome'' research (whether in the form of ''research on the effectiveness of behavioral and cognitive behavioral interventions'' or ''therapist or treatment intervention by patient type'') tended to constitute a smaller proportion of the examples provided (approximately 25%). This pattern is consistent with Morrow-Bradley and Elliott's (1986) finding that clinicians tend to find research related to therapy process more clinically useful than research on therapy outcome, and with the argument made by many psychotherapy researchers over the last three decades that an increased emphasis on conducting research illuminating the process or mechanisms through which change takes place will be critical if we are going to advance the field of psychotherapy research and reduce the gap between research and practice (Goldfried & Wolfe, 1998; Greenberg, 1986; Safran & Muran, 1994; Westen et al., 2004).

A final pattern worth noting is that despite the fact that only 10% of the sample identified themselves as cognitive behavioral therapists (CBT) compared to 35% who identified themselves as psychodynamic, an approximately equal number of ''research on the effectiveness of CBT interventions'' and ''psychodynamically oriented research'' examples were provided. Interestingly, the CBT-oriented research examples provided tended to focus on therapy outcome, whereas examples of psychodynamically oriented research provided tended to focus on various aspects of the therapeutic process. This may reflect a general tendency for psychodynamically oriented therapists to be less compelled by evidence demonstrating that their preferred orientation works, than they are in understanding the process through which it works. This emphasis on the importance of understanding underlying principles rather than learning specific techniques is a central theme in contemporary psychoanalytic thinking (e.g., Aron, 1999; Hoffman, 2009). Given the fact that approximately 90% of respondents did not identify themselves as cognitive behavioral in orientation, these findings may also suggest that psychodynamic and other non-CBT-oriented therapists in our sample learn less from research demonstrating the effectiveness of their preferred orientations than they do from evidence regarding the effectiveness of various CBT techniques. It may also be indicative of a receptiveness among this sample of researcher-clinicians to being influenced by empirical evidence regarding the effectiveness of therapeutic approaches outside of their preferred theoretical orientation.

There are a number of limitations to this survey. The most important concern is the relatively low return rate. The major issue here is the possibility of a nonrepresentative sampling of the SPR membership as a whole. While we cannot rule out this possibility, the absence of significant differences on most of the important sample characteristics between our respondents and a larger sample of SPR members does provide evidence of the representativeness of our findings with respect to the larger membership. The exceptions were on the characteristics of sample age, years of clinical experience, and theoretical orientation. In these areas, there was some evidence that we may have undersampled some of the older SPR members who tended to have more years of clinical experience. In addition, we may have undersampled psychodynamically oriented members and oversampled those designating themselves as eclectic. On the face of it, however, these are not factors that are likely to have influenced our findings in the direction of underestimating the perceived clinical utility of research relative to other sources of information for SPR members. For example, given the evidence that psychodynamically oriented clinicians are less likely to view research as relevant to their clinical work than clinicians of other orientation (Morrow-Bradley & Elliott, 1986; Stewart & Chambless, 2007), one might hypothesize that the underrepresentation of dynamic clinicians in our sample resulted in inflated estimates of research utilization. Similarly, one might hypothesize that more clinical experience might translate into weighting the value of clinical experience more highly.

Another limitation of the study is that members of SPR cannot necessarily be considered to be representative of all researcher–clinicians. The culture of SPR has always placed an important emphasis on the value of conducting clinically meaningful research and on the importance of research and clinical practice functioning as mutually influential activities (see, e.g., Castonguay et al., 2010). A third concern is that while the Morrow-Bradley and Elliott (1986) survey of APA Division 29 members in some respects served as a useful comparison sample for purposes of examining the responses of the current sample, the use of a

somewhat different format for the rating scale and anchors for one of the key questions (i.e., evaluating the overall impact of research on clinical practice) makes it critical that any inferences about similarities and differences in the attitudes of the two samples on this question be drawn cautiously. Moreover, it would have been helpful to be able to compare our findings with a more current survey of Division 29 members' attitudes toward psychotherapy research. A final concern is that respondents' answers to the open-ended question about examples of clinically meaningful research findings were categorized and classified through qualitative analysis procedures, and no inter-rater rating of category classification was calculated. The category percentages provided in the results section are thus only rough estimates inevitably influenced by our subjectively based categorization of the items.

The above limitations notwithstanding, the current survey does shed some light on the attitudes of a sample of researcher–clinicians regarding the clinical relevance of psychotherapy research. Depending upon how one looks at the findings, one can see the glass as either half empty or half full.

Given the active involvement and investment of this sample in the enterprise of psychotherapy research, and the complexity of their attitudes (described earlier), it would be difficult to argue that they display what Baker et al. (2009, p. 83) have termed an ''insouciance'' in the face of research evidence. It seems rather that they value research, but only as one of many sources of information relevant to their clinical work (and in some respects less than a number of other sources of information, including personal clinical experience). Given the fact that the sample is clearly conversant with the latest research, it is difficult to attribute the findings to a ''dissemination problem.'' How then can we account for our findings?

One possibility is that unwillingness of this sample to privilege research findings as a source of influence on their clinical practice in part reflects limitations in the current state of the art of psychotherapy research. Despite consistent efforts to improve the clinical utility of psychotherapy research over the last few decades, we cannot assume that future developments in research methodology will not further increase its clinical utility. In fact, a total of 84% of our sample was either ''somewhat optimistic'' or ''strongly optimistic'' about the *potential impact of psychotherapy research in the future*.

A second possibility to consider is that it may actually be the case that optimal use of information generated by empirical research *is* as one source of information to be combined by the clinician with others (e.g., clinical experience, experience in clinical supervision, existing theory). Since the publication in the early 1980s of Donald Schon's classic work on the nature of professional expertise (Schon, 1983), an important field of interdisciplinary investigation has emerged that studies the process through which experts make decisions that guide their actions in real-world situations that are complex and ambiguous in nature (e.g., Collins, 2010; Dreyfus & Dreyfus, 1986; Ericsson, 2009; Klein, 1998, 2009). Research in this field (commonly referred to as the field of *naturalistic decision-making*) has consistently found that skilled practitioners across a wide range of professions respond to relevant situations in a flexible, creative, and contextually sensitive fashion. Unlike novices, who tend to apply procedures (based on theory, research findings, or both) in a standardized fashion, experts engage in what Schon (1983) refers to as *reflection-in-action*—that is, principles of procedure are continuously elaborated in response to an ongoing appraisal of the emergent situation. Knowledge acquired from multiple sources, including training, theory, research, and professional experience, is stored at a tacit level and establishes the context for a type of *holistic pattern analysis* that permits them to ''see'' emerging possibilities for intervention (Safran & Muran, 2000). Whether or not this is true for skilled psychotherapists is an empirical question.

NOTES

1. Direct comparison of the two samples with respect to theoretical orientation is complicated by the fact that Morrow-Bradley and Elliott (1986) did not provide respondents with the option of designating themselves as humanistic.

2. A social science researcher with considerable expertise in qualitative research.

3. The senior author is psychoanalytically oriented and conducts research on the therapeutic alliance and other aspects of psychotherapy process and outcome. The three

primary coders were graduate students in psychology with eclectic orientations and a basic command of the psychotherapy research literature.

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Received September 19, 2011; accepted September 21, 2011.