Introduction to a special section on practice-based research and counselling psychology

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I am delighted to present this special guest-edited section of the Counselling Psychology Quarterly focusing on practice-based research and counselling psychology. Practice-based research (PBR) is a rich set of discourses. Following on from the classical distinction between efficacy and effectiveness, PBR often refers to research carried out in real world or naturalistic psychotherapy contexts as opposed to experimental research contexts (Barkham, Stiles, Lambert, & Mellor-Clark, 2010; Seligman, 1995). It is also associated with a diverse and fascinating history (and promising future) of bespoke quantitative, qualitative and mixed research methods, including research case studies, psychotherapy process research, and effectiveness research (Stiles, Hill, & Elliott, 2015). It has been suggested that, if developed within systematic research programmes, PBR has the potential to influence clinical guidelines (Barkham & Parry, 2008; McLeod & Elliott, 2011). Finally, although it is possible that most PBR is actually conducted by researchers and academics (Henton, 2012), given its closer proximity to practice, it might be the kind of research practitioners could be drawn into doing, spurred on by the myriad curiosities arising from day-to-day therapeutic work (Bager-Charleson, 2014).

This special section aimed to explore counselling psychology's relationship with PBR with a call for papers based on an open and broad set of questions: How is PBR understood and practiced within counselling psychology? What experiences do counselling psychologists or other helping professionals have of carrying out PBR? What are the practical, methodological, and ethical issues involved in engaging in PBR? And how does evidence from PBR influence professional practice guidelines?

Coming from a United Kingdom (UK) perspective, although there is increasing interest in practitioners' experiences of research and their views of research/practice relationship
(e.g., Bager-Charleson, McBeath, & du Plock, 2018), it has been noted that counselling psychologists generally do not enter the field to become researchers (Henton, 2016), do little research (Gordon & Hanley, 2013), and face numerous barriers to carrying out research post-qualification (Apostolopoulou & Skourteli, 2015).

A small number of UK trainings have adopted, or are beginning to adopt, the US “practice-research network within the university clinic” model, to provide trainees with more integrated research/practice experiences and encourage their future research careers. However, the dynamics involved when training, practice, research and evaluation are all mixed together can be challenging for trainers and trainees alike (Castonguay, Pincus, & McAleavey, 2015; Van Rijn et al., 2008). In the absence of the university clinic model, and given that clinical psychology trainings have a subsidized foothold in the UK National Health Service (NHS), there is perhaps a greater difficulty finding a place for PBR in UK counselling psychology training contexts than in US and other contexts.

In some ways, the papers in this special section may be reflective of these current challenges. Two papers emanate from established practice-based research projects among leading psychotherapy and clinical psychology researchers in Norway and Portugal. These papers are both about doing practice-based research at a “meta” level. The third paper is a “doing” of practice-based research by a UK counselling psychologist in training at the time of the call for papers.

It is a great privilege to present these three papers for this special section of the Counselling Psychology Quarterly. May I sincerely thank the authors for their diligence and patience in the process of getting to publication. I hope you will find the papers presented interesting and thought-provoking.

The papers in the special section

In the first paper of the section, Halvorsen, Benum, Oddli, Stānicke, & McLeod (this issue) asked twelve highly experienced psychotherapists (11 clinical psychologists and one psychiatrist) for their reflections on participating in practice-based research. Data were drawn from a wider mixed-methods process-outcome study involving 18 therapists and 48 private practice clients in a practice research network collaboration with the University of Oslo, Norway (Rønnestad, 2009; Rønnestad et al., 2014). This wider project included a standardized protocol of process and outcome measures, session audio-recordings, clients’ and therapists’ session evaluations, and interviews post-termination and after three or four years.

For Halvorsen et al.’s follow-up study (this issue), data about therapists’ experience of participation were gathered via an open-ended questionnaire and analyzed using a thematic analytic approach. Themes generated included (1) Being observed, acting differently as a therapist – the experience of being recorded introduced both an imagined critical gaze and a beneficial helper into the therapy room; (2) The impact of research devices – both being caught up in research procedures and taking control over devices to facilitate the alliance; and (3) Learning from participation – how research procedures, while challenging, facilitated reflection on clinical practice and generated greater confidence and trust in psychotherapy research.

The idea that research procedures disrupt “treatment as usual” fits with previous research, for example about the impact of research recording in the context of psychoanalysis (Busch et al., 2001; Henton & Midgley, 2012). However, this paper raises an
interesting question about whether in the context of practice-based research, treatment as usual remains a stable and discrete entity for research to “disrupt.” Alternatively, is there a complex, relational and at times paradoxical matrix of experience for therapists, reflective of inner thoughts and feelings that cannot necessarily be separated out into practice and research categories? It might also be argued that given the current climate, in which outcome measurement is commonplace in routine clinical practice, the discursive binary between treatment as usual versus treatment in a research setting is becoming less meaningful and less warranted.

In the second paper, Antunes, Sales, and Elliot (this issue) focus in on therapists’ perceptions of the clinical utility of a particular practice-based research instrument, the individualized Personal Questionnaire outcome measure (PQ). The PQ was originally developed by David Shapiro in 1961, out of a wish for an outcome measure that could be tailored to clients, while still capable of use for research comparisons, and subsequently adapted (Elliott et al., 2016). At an initial pre-therapy appointment, the client completes a blank "Problem Description Form" in collaboration with the therapist, a researcher or an assessor. This process requires five structured stages (generating, refining, prioritizing, and rating the severity of problem items, then completing the PQ) and takes roughly twenty to thirty minutes to complete. On later administrations, clients rate the items for severity.

The value and utility of routine outcome measurement in psychotherapy practice is a matter of debate. In the context of managed care, for example, proponents argue it increases understanding, accountability and decision-making for clinicians, clients, services and commissioning bodies (e.g., Boswell, Kraus, Miller, & Lambert, 2013). Detractors, for instance in the context of the changes in the last 10 years in the UK’s NHS, argue that outcome measurement practices are part of a wider disavowal of the emotional realities and complexities of suffering and helping, and a new virtual reality that privileges organisational target setting and performance management in an increasingly consumerist, marketized environment (Rizq, 2012).

Developments such as the PQ perhaps occupy a middle space between these opposing concerns. The PQ aims to meet criteria for an evidentiary distress measure, by demonstrating good internal and temporal reliability, and by correlations with nomothetic outcome measures. It can identify change between sessions, and over the duration of therapy (Elliott et al., 2016). At the same time, it may be more appealing both to clients and therapists, given its constructivist, client-centered method, which makes central use of the client’s language and meaning-making. Thus, the PQ is aligned to some extent in method and values with one recent development of pluralistic therapy, in which client and therapist mutually agree on the nature of therapy’s goals, tasks and bonds (Bordin, 1979; Cooper & McLeod, 2010).

Antunes et al. (this issue) defined clinical utility from an amalgam of sources as involving three domains: feasibility for therapists, acceptability to clients, and generalizability to clinical groups and settings (American Psychological Association, 2002; Fitzpatrick, Davey, Buxton, & Jones, 1998; Slade, Thornicroft, & Glover, 1999). Following a framework analysis of data from an initial focus group involving five Portuguese psychotherapists with PQ experience, a 70-item “Utility-PQ” questionnaire, with a five-point scale from 0 to 4, was generated and administered to 25 therapists, also with previous PQ experience of between one and five years.

Scores for generalizability across different age groups, clinical approaches, and settings were the strongest of the three domains, with global means ranging from 3.26 to 3.49. Feasibility scores measuring therapist adherence, and value to clinical practice, were also
moderately high with global means of 3.05 and 2.81 respectively. Scores for acceptability to clients, covering the emotional impact on clients, and clients’ general receptiveness, were somewhat lower with global means of 2.56 and 2.54 respectively. To increase acceptability, participants advised that the protocol be developed to ensure clients had greater opportunity to reflect on their difficulties prior to the pre-therapy assessment, and there was further emphasis on the importance of therapists using the PQ in creative and flexible ways. This distinction between the “what” of any therapeutic or research intervention (and here the two are combined) and the “how” is an important one, and has been highlighted in other studies of outcome measurement experience among therapists (e.g., Unsworth, Cowie, & Green, 2012). Here it is suggested that client-centeredness needs to be as much in the process as in the content of the PQ intervention.

Finally, Tarabi, Loulopoulou, and Henton (this issue) used an interpretative phenomenological method to explore the experiences of six second-generation Pakistani Muslim men (PMM) who had completed 10 to 16 sessions of cognitive-behavioural therapy (CBT) in a UK charity setting. Against background literatures exploring the fit between CBT and Islam, including modified CBT outcome studies among relatively heterogenous South Asian samples (e.g., Naeem, Waheed, Gobbi, Ayub, & Kingdon, 2011), there have been relatively few qualitative studies of CBT experience among particular groups such as PMM. This seems an important knowledge gap to address given that second-generation PMM are a large, growing community in the UK currently under-using mental health services (Cooper et al., 2013).

This study privileges the idiographic, paying attention to divergences in meaning-making between participants, and producing useful domains of further enquiry for referral and assessment services within these communities. For example, some participants valued CBT for its directive “guiding” approach to therapy, while others appeared to value the explorative aspects of CBT more closely resembling a “conversation.” Some participants found being matched with a Muslim therapist helped in “tailoring” therapy to their needs, while others expressed that this made exploring “taboo” subjects more difficult and created an intruding, more judgmental atmosphere, as if coming in from the outside. In a finding not identified in previously research, some participants suggested CBT had brought them closer to their religion, by providing a space to explore and question, thus gaining deeper understandings. This finding may again be a useful starting point for dialogue among service-user or community forums that explore barriers to help-seeking among Muslim communities.

Finally, some participants expressed dislike of the language of CBT practice, for example “homework.” This seemed not to be about translation, but instead about the need for a more sensitive process of language identification and use, to ensure CBT speaks more relevantly to clients. As the authors argue, this form of client-centeredness is an assumed facet of all good quality, responsive therapeutic work, regardless of modality, setting or client group.

Concluding reflections

Of the three papers in this special section, both Halvorsen et al. and Tarabi et al. delve hermeneutically into therapy’s rich phenomenological territories revealing complexities and divergences in therapists’ and clients’ sense-making, even if one paper is about practice in
the context of practice-based research, the other paper simply about a practice context. Clearly, similar experiences in therapy can mean different things to different people – some feel caught up in research procedures, others feel they can control them; for some, CBT is a guide, for others, a conversation. Both studies allude at times to the presence of “thirds,” sometimes unwelcome thirds, entering the intersubjective space – the imagined critical gaze behind session recordings, or judgments entering the room from the outside when a taboo subject is explored.

It is interesting to conceptualise these unwelcome thirds intruding into the client-therapist dyad as an Oedipal dynamic (Freud, 1923/1991), a triangular constellation of two, with a third entering. Originally conceived of as mother/child and father in early experience, it has been argued that this dynamic may fundamentally imprint the structure of the mind, with an intrapsychic third representing a critical superego, for instance (Loewald, 2000). From the studies presented in this special section, it seems as if the two of the therapy dyad may be joined by a third in numerous and divergent ways, and disruption in therapy, whatever the context, can therefore come from or be identified with more than one source. Perhaps this observation in and of itself disrupts the binary opposition often drawn up between undisrupted “naturalistic” “real-world” “treatment as usual” on the one hand and disrupted or disrupt-able “treatment in a research setting” on the other. It lends further weight, perhaps, given psychoanalytic understandings of the structure of mind and experience, to the idea that such disruption may be a feature of all therapeutic work, regardless of its practice or research context.

Both Antunes et al. (this issue) and Tarabi et al. (this issue) highlight the importance of client-centeredness in the languaging of therapeutic work. In Antunes et al., this seems to strike to the heart of the endeavor in developing the PQ, an outcome measure attempting to be both evidence-generating and centered around the language and world of the other in a pluralist ethic. As with many PBR methods, both the creation and use of the PQ is reminiscent of Lévi-Strauss’s (1966) “bricolage” – a piecing together from what is at hand, and of Bourdieu’s (1977) “habitus” – a form of improvisation that breaks down dichotomies such as research/practice and subjective/objective. In relation to the perceived dichotomy between research and practice, postmodern “différence” (Derrida & Bass, 1982) suggests the meaning of each is continually deferred and defined in binary opposition to the other. By emphasizing the play of meaning, différence paradoxically implies potential in-difference or alikeness between apparently opposing phenomena, and perhaps greater potential for integration or equity between research and practice (Henton, 2015). As a between or both-and phenomenon in pluralist, postmodern cultures of research and practice, PBR has much to offer. I hope this special section makes a contribution to counselling psychology’s continued interest and engagement in this field.

Disclosure statement

No potential conflict of interest was reported by the author.

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