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What Clinicians Want: Findings From a Psychotherapy Practice Research Network Survey

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Practice research networks may be one way of advancing knowledge translation and exchange (KTE) in psychotherapy. In this study, we document this process by first asking clinicians what they want from

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continued

psychotherapy research. Eighty-two psychotherapists in 10 focus groups identified and discussed psychotherapy research topics relevant to their practices. An analysis of these discussions led to the development of 41 survey items. In an online survey, 1,019 participants, mostly practicing clinicians, rated the importance to their clinical work of these 41 psychotherapy research topics. Ratings were reduced using a principal components analysis in which 9 psychotherapy research themes emerged, accounting for 60.66% of the variance. Two postsurvey focus groups of clinicians ($N = 22$) aided in interpreting the findings. The ranking of research themes from most to least important were—Therapeutic Relationship/Mechanisms of Change, Therapist Factors, Training and Professional Development, Client Factors, Barriers and Stigma, Technology and Adjunctive Interventions, Progress Monitoring, Matching Clients to Therapist or Therapy, and Treatment Manuals. Few differences were noted in rankings based on participant age or primary therapeutic orientation. Postsurvey focus group participants were not surprised by the top-rated items, as they were considered most proximal and relevant to therapists and their work with clients during therapy sessions. Lower ranked items may be perceived as externally imposed agendas on the therapist and therapy. We discuss practice research networks as a means of creating new collaborations consistent with KTE goals. Findings of this study can help to direct practitioner–researcher collaborations.

Keywords: psychotherapy, psychotherapists, knowledge translation, practice research networks, survey

There is a well-documented gap between practice and research in psychotherapy (Beutler, Williams, Wakefield, & Entwistle, 1995; Boisvert & Faust, 2006; Castonguay, Barkham, Lutz, & McAleavy, 2013; Wilson, Armoutliev, Yakunina, & Werth, 2009). Clinicians often feel that research findings do not reflect their practice realities, and so they do not consistently use research to inform their practices. For example, surveys demonstrate that clinicians do not rely on research to determine their interventions (Tobin, Banker, Weisberg, & Bowers, 2007; von Ranson, Wallace, & Stevenson, 2013). On the other hand, some have argued that researchers may place a lower premium on information gleaned from clinicians and may not readily use this information to inform their research (Beutler et al., 1995). As a result, research based on randomized trials may not be perceived by clinicians as immediately relevant to their practice realities (Westen, Novotny, & Thompson-Brenner, 2004) despite the potential utility of the research.

The prevailing paradigm in psychotherapy research is that researchers know what is important to study and then proceed to conduct the research. Hence, psychotherapy research, research questions, methods, and interventions are often defined exclusively by researchers and not by the community of users (i.e., clinicians) or patients (Beutler et al., 1995). These groups (researchers, clinicians, and patients) may have different priorities for research and treatment. For example, the focus on symptom reduction by researchers in randomized controlled trials suggests that researchers primarily value symptomatic outcomes when evaluating psychotherapies even though these studies often also measure other areas of psychosocial functioning. However, surveys of patients indicate that they value improved self-respect, better work functioning, and improved social functioning, as well as fewer symptoms (Bohart & Wade, 2013). Similarly, what clinicians want from research may be different from what researchers currently prioritize. This does not divest clinicians from their responsibility to use best practices with their patients. However, if these divergent priorities (i.e., what clinicians want vs. what interests researchers) are not reconciled, then it is less likely that clinicians will adopt research findings to inform their practices And if research is not adopted in everyday practice, then patients will not benefit from the accumulated knowledge base.

A useful way to conceptualize this practice–research gap is to contrast knowledge dissemination with knowledge translation and exchange (KTE; Graham et al., 2006). The prevailing focus in psychotherapy research has been on disseminating findings to clinicians by traditional routes that include researchers publishing in academic journals, creating lists of evidence-based practices (APA Presidential Task Force on Evidence-Based Practice, 2006; Hunsley, Elliott, & Therrien, 2014; Norcross & Lambert, 2011), and developing best practice guidelines (American Psychiatric Association, 2006; National Institute for Health and Care Excellence [NICE], 2011). By contrast, KTE assumes that participants in a research endeavor are equal partners with valuable knowledge to exchange. In KTE the partnership begins before the research questions, design, and methods are discussed. Graham et al. (2006) conceptualize the action phase of KTE as occurring in several

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stages: (a) *identifying the problem*, such as the research–practice divide in psychotherapy; (b) *assessing barriers*, such as attitudes, perceived behavioral control, and social norms (Tasca, Grenon, Fortin-Langelier, & Chyurlia, 2014); (c) *designing an intervention* for the problem, such as developing a practice research network (PRN, which are discussed below; Castonguay et al., 2013); and (d) *monitoring knowledge use/outcomes* in which clinicians use the research that they helped to develop to inform their practice, and in which researchers use clinicians' knowledge to inform the development of their research. One of the useful aspects of KTE is that it points to specific interventions to overcome barriers. For example, developing a PRN, which is a means of creating unique partnerships between clinicians and researchers, may lead to important changes in the attitudes toward research or practice, a greater sense of efficacy about applying research to practice or about practice informing research, and a realignment of social norms among those who participate because of the partnerships that they form (Tasca et al., 2014).

The study presented in this article occurred in the context of developing the psychotherapy practice research network (PPRNet), and we report findings of a survey of clinicians' research priorities. We systematically asked clinicians about their research priorities with the intent of using these priorities to inform psychotherapy research that will engage clinicians in practice-based research, which will in turn be translated into clinical practice. To develop the PPRNet, we adopted a participatory action research (PAR) orientation. PAR is sometimes referred to as community-based participatory research (Jones & Wells, 2007). In PAR, researchers collaborate with communities in a mutually respectful research endeavor in which both partners exchange knowledge and education, and the findings are immediately put into action by the communities involved. Further, both sets of participants expect to be transformed by the process of collaborating. Historically, PAR has occurred in social justice contexts in which the research was designed to help study and improve circumstances of a disadvantaged community that might have felt distrust toward academic research (Macaulay et al., 1999). Ideally, the benefit of PAR is realized by its focus on the relationship between the community and researchers, the immediate research outcomes for the community, and the community's involvement from the outset (Macaulay et al., 1999). PAR emphasizes jointly negotiated agreements, and sharing decision making from design to interpretation of results to dissemination of findings. The traditional psychotherapy research paradigm considers clinicians as passive recipients of research knowledge. A PAR approach recognizes clinicians as experts with knowledge that is necessary to make research relevant and applicable, and as active consumers. We expect that both the nature of the collaboration and the psychotherapy research results will lead to a smaller gap between practice and research.

Following the KTE model and PAR approach, the PPRNet's first goal was to consult with members of the psychotherapy community regarding the conduct of practice-based psychotherapy research. We did so in order to define research priorities that were important to the community of clinicians. Below we describe the development of a survey of psychotherapists in which clinicians were asked to rate the importance of research areas in psychotherapy, and we report the findings of the survey that could inform psychotherapy research priorities in the network and in the general research community.

The study took place in three stages using a mixed-method approach. First, to define research areas for the survey, we ran focus groups of clinicians (Morgan, 1997) and used an inductive qualitative approach to coding the detailed notes taken from the groups (Thomas, 2006). The goal of the coding was to create a set of survey items that captured the variety of research topics proposed by participants in the focus groups. Second, we conducted an online survey of psychotherapists, researchers, and students, and results were tabulated. A principal components analysis was used to reduce the survey data into meaningful components. Third, we conducted two more focus groups of clinicians to help us to interpret the survey findings.

Method

Presurvey Focus Groups

In November 2012, the PPRNet hosted a conference on practice-based research in psychotherapy in Ottawa, Canada. The conference brought together 82 clinicians, researchers, educators, and representatives of professional organizations. Participants were invited to attend the conference through e-mails sent by professional organizations to their membership (e.g., Canadian Counselling and Psychotherapy Association, Canadian Group Psychotherapy Association, Canadian Mental Health Association, Canadian Psychoanalytic Society, Canadian Psychological Association; Canadian Psychiatric Association, General Practice Psychotherapy Association, and the Ontario Association of Social Workers). One conference activity involved 10 focus groups of about 8 participants each in part to develop a preliminary list of research topics that are particularly salient to clinicians. Of these participants, mean age was 49.38 ($SD = 12.94$), 61.2% were women, 52.9% were psychologists, 5.9% were students, 54.4% had a Ph.D, 17.6% had an M.D, 10.9% had a masters degree, and 9.7% had a masters-level social work degree. Each focus group was moderated by a member of the PPRNet Working Group (i.e., clinicians and researchers who developed the PPRNet), and each group was audio recorded and a recorder took notes. Prior to the conference, focus group moderators and recorders attended a half-day training session focused on maintaining fidelity of the focus groups and reducing bias. In the focus groups, moderators asked participants questions such as "Think about a time when you were unsure how to proceed in your practice, or with a client. What information could have helped you out?"; "Think about when you were beginning your practice. What are some of the things you wish you had known about?"; and "What research themes would you like PPRNet to address? These could be themes that might help you to improve your skills, strengthen your practice, and help your clients."

Following the conference, focus group recorder notes and audio recordings were reviewed by a small team of three coders who were tasked with categorizing the content of the data. The team took an atheoretical inductive approach to the qualitative coding (Thomas, 2006). The group worked together to review data from one focus group, identifying statements concerning proposed research questions, issues, or topics the PPRNet could undertake. The team assigned each of these statements a code. These codes were then grouped into larger categories based on their similarities, and the categories were provisionally defined. Then working independently, the three coders coded the remaining focus groups. The coding from each coder was subsequently verified by other team members. From this process four broad categories of codes were identified (described below), along with a list of subcategories that grouped more specific research issues or topics.

To verify the validity of the coding, two steps were taken. First, the focus group moderators and recorders reviewed the categories and codes to make sure that the discussions in their groups were adequately represented. Second, a PPRNet Reference Group, made up of eight clinicians who attended the conference and identified by focus group moderators as opinion leaders in their practice communities (Canadian Institutes of Health Research, 2012), also reviewed the coded content and gave feedback.

Item Development and Online Survey

A team of seven clinicians and researchers then met on three occasions to develop survey items from the focus group data at the subcategory level within each major category. Forty-one items were derived from the content analysis. The survey items were pilot tested for clarity, readability, and content by six clinicians of the PPRNet Reference Group. These six clinicians completed the survey online and were instructed to make notes on any items that were not clearly written or were ambiguous. Then they met with two members of the survey development team to discuss their comments. The survey development team made changes to the wording of some items based on this feedback.

Online survey participants were recruited by an e-mail sent: from the professional practice organizations listed above and also including the Ontario Association of Consultants, Counselors, Psychometrists, and Psychotherapists; through listserves of psychological associations in several Canadian provinces (i.e., Alberta, Ontario, Quebec, Nova Scotia); through national and international professional listserves (American Group Psychotherapy Association, Canadian Association of Cognitive Behavioral Therapy, Canadian Council of Professional Psychology Programs, Eating Disorders Research Society, Psychodynamic Research Listserve, Society for the Exploration of Psychotherapy Integration, Society for Psychotherapy Research); and the PPRNet membership list. E-mails included a link to the survey site hosted by FluidSurveys. A reminder e-mail was sent through each of these groups approximately one month following the initial e-mail. The survey link was also provided on the PPRNet Web site at *www.pprnet.ca*. The survey was open from November 2013 to January 2014.

Online survey participants were told that the study's purpose was to use their ratings to rank-order psychotherapy research priorities that were generated by focus groups composed of psychotherapists and researchers, and that the rank ordering will help to define future practice-based research by the PPRNet. In the introductory text to the survey, participants were instructed to "Rate the importance of the following psychotherapy research areas to your psychotherapy practice." The stem for the items was "How important is it to you to have practice-based research on." Items were rated on a 5 point scale from 0 ("not important"), 1 ("slightly important"), 2 ("moderately important"), 3 ("very important"), and 4 ("extremely important"). Following previous studies using Delphi techniques, we assessed degree of consensus on most important research areas within our sample by the percent of items rated as "very important" or "extremely important" (i.e., rated ≥ 3; McIlfatrick & Keeney, 2003). There is no general agreement in this literature on what percentage constitutes consensus among respondents; however, a review by McIlfatrick and Keeney (2003) indicated that the rate of agreement to indicate consensus in a sample has varied in the research literature from 51% to 70% (see Mcilfatrick & Keeney, 2003 for a review). Following Mcilfatrick and Keeney (2003), we contrasted the high consensus top items that were rated as "very important" or "extremely important" (≥ 3) by $>70\%$ of the sample, versus the bottom items that were rated "very important" or "extremely important" by $<51\%$ of the sample. A demographics questionnaire followed the survey items. The total sample of respondents was $N = 1{,}019$. Of those, $n = 166$ were either "friends" or "members" of the PPRNet, representing 30.18% of the PPRNet list at the time of the survey. The number of ratings of the 41 items ranged from 943 to 1,006, and we present item ranking based on all available data. Detailed demographic information of the online sample is provided in Table 1.

Postsurvey Focus Groups

To aid in interpreting the findings of the survey, we conducted two focus groups of 21 clinicians. One focus group was composed of members of the PPRNet Reference Group. The second focus group was largely composed of clinicians who were not previously associated with the PPRNet and were invited because they were identified by PPRNet Working Group members as opinion leaders in their practice communities (Canadian Institutes of Health Research, 2012). Mean age of participants was 54.33 years ($SD = 10.60$), and 50% percent were female. The sample included six psychologists, five psychiatrists, five family physicians who practice psychotherapy, three social workers, one counselor, and one occupational therapist. Participants were asked questions about the survey findings, such as "Were the ranking of items what you expected?," "Were you surprised by any of the rankings that were high or low?," "Which ratings were not surprising?," "Why do you think participants rated these items as high priorities/low priorities?," "Are the rankings representative of clinicians' research priorities?" Focus groups were audio recorded, and notes were made from the recordings of participants' responses to these questions. Responses were then categorized into prominent themes that emerged.

All components and procedures of these studies were approved by the Ottawa Health Sciences Research Ethics Board. All participants provided informed consent.

Results

Presurvey Focus Groups

As indicated, we used an iterative process of developing and modifying themes and categories that emerged from the focus group notes and audio recording and that reflected the clinicians' priorities for psychotherapy research that is important to their practice. First, four major categories were identified, and within each major category, subcategories with examples were listed. (a)

Table 1
Survey Respondents' Demographics

Demographic	Valid N	Mean	*SD*
Age	935	49.00	13.36
Hrs/week practicing psychotherapy	872	19.21	11.30
Years practicing psychotherapy	879	17.58	11.32
Demographic	Valid N	Frequency	Percent
Language of survey	1,019		
English		771	75.7
French		248	24.3
Gender (Female)	946	632	66.8
Population group[a]			
Aboriginal		30	2.8
Black		35	3.3
Chinese		36	3.4
Latin American		38	3.6
South Asian/East Indian		33	3.1
West Asian/Afgan/Iranian		19	1.8
White		844	78.6
Other		39	3.6
Highest education	955		
Bachelors		40	4.2
Doctorate		430	45.0
Masters		253	26.5
Medical degree		94	9.8
Other		138	14.4
Currently practicing psychotherapy	951	888	93.4
Primary profession	950		
Counsellor		50	5.3
Family physician		27	2.8
Psychiatrist		75	7.9
Psychologist		562	59.2
Researcher		13	1.4
Social worker		54	5.7
Student		57	6.0
Other		100	10.5
Country	875		
Canada		746	85.3
United States		95	10.9
Europe		24	2.7
South America		10	1.1
Primary practice setting	850		
Academic center		76	8.9
Community agency		89	10.5
Hospital		158	18.6
Family practice team		16	1.9
School		17	2.0
Private practice		411	48.4
Other		83	9.8
Primary theoretical orientation	857		
CBT/BT/DBT		289	33.7
Eclectic/Integrative		157	18.3
Emotion Focused/Existential/ Humanistic		113	5.0
Family/Systems		44	5.1
Psychodynamic/Psychoanalytic		189	22.0
Constructionist/Postmodern		12	1.4
Interpersonal		1	0.1
Other		52	6.1
Primary client category	856		
Children/Adolescents		113	13.2
Adults/Older Adults		743	86.8
Primary type of therapy	863		
Couple/Family		30	3.5
Group		38	4.4
Individual		785	91.0
Other		10	1.2

Note. CBT = cognitive–behavioral therapy; BT = behavior therapy; or DBT = dialectical behavior therapy.
[a] Participants had the option to choose more than one population group membership, so numbers do not add up to the sample total.

The Professional or Practice Issues major category included research questions concerned with factors or issues that are broadly related to the profession of psychotherapy or the practice of psychotherapists. They represented distal influences on particular psychotherapy practices or psychotherapeutic interventions, processes, or outcomes. Subcategories included cost-effectiveness, professional development, treatment fidelity, progress monitoring, access to psychotherapy, and stigma. (b) The Therapeutic Inputs major category included research questions concerned with factors that exist prior to a therapeutic intervention that may influence the nature, course, or outcomes of a therapeutic intervention. Unlike the Professional or Practice Issues major category, these factors have a more proximal association to therapeutic interventions. Subcategories of Therapeutic Inputs included client characteristics, therapist characteristics, client and therapist match, training of new therapists, and preparing clients for therapy. (c) The Therapeutic Interventions and Processes major category included research questions concerned with factors associated with the nature or course of particular therapeutic interventions and processes. This major category also included research questions concerning the effects of implementing particular types of therapies or interventions on aspects of the therapeutic relationship. Subcategories included progress monitoring, using technology, the therapeutic relationship, fidelity to therapy approaches, complementary treatments, training of psychotherapists, and therapists' internal experiences. (d) The Therapy Outcomes major category included research questions concerned with various factors associated with short-term or long-term client outcomes of psychotherapeutic interventions. Subcategories included progress monitoring, using technologies, complementary treatments, treatment fidelity, complex clients, stigma, cultural competence, training and professional development, and effective therapies.

Online Survey

As indicated previously the subcategories identified in the focus group data formed the basis of the online survey items, and 41 items were developed. Some content areas were repeated across items if the content area appeared in more than one major category. For example, items on progress monitoring appeared in the major category on Therapeutic Interventions and Processes (i.e., "How important is it to you to have practice-based research on the effects of the following on therapeutic processes: regular standardized client self-report and feedback"), and in the major category on Therapeutic Outcomes (i.e., "How important is it to you to have practice-based research on the effect of the following on therapy outcomes: regular standardized client self-report and feedback").

Table 2 shows the rank ordering of items based on the mean ratings of survey respondents, and indicates in which major category each item appeared. The table also indicates the percentage of individuals who rated a research area ≥ 3, that is, as "very important" or "extremely important" to their practice. More than 70% of participants rated the top nine items as very or extremely important research areas for their practice, indicating consensus among our sample on the importance of these items (Mcilfatrick & Keeney, 2003). There was little consensus on the importance of the bottom 15 items, which were rated as very or extremely important research areas by $<51\%$ of the sample.

Table 2

Survey Item Means (M), Standard Deviations (SD), and Percentage of Those Who Rated Each Items as Very or Extremely Important (% Rated ≥ 3)

Rank	How important is it to you to have practice-based research on:	Survey major category	*N*	*M*	*SD*	% rated ≥ 3
1	Understanding the mechanisms of change in therapy	Therapeutic interventions and processes	960	3.36	.77	88.5
2	The therapeutic relationship	Therapy outcomes	943	3.33	.83	84.4
3	Methods to effectively train psychotherapists	Professional and practice issues	983	3.07	.88	78.4
4	Psychotherapists' use of reflection to improve their own clinical practice (e.g., knowing when to refer; recognizing when an intervention is not effective)	Professional and practice issues	994	3.07	.89	77.3
5	Problems in the therapeutic relationship (e.g., ruptures and repair of the alliance)	Therapeutic interventions and processes	954	3.05	.87	76.4
6	Tailoring psychotherapy to the client's motivation, expectations, and readiness	Therapeutic inputs	961	2.99	.88	75.9
7	Client symptoms and characteristics	Therapy outcomes	954	2.93	.85	74.6
8	Psychotherapists' training or professional development	Therapy outcomes	951	2.93	.88	73.6
9	Common factors across psychotherapy approaches (e.g., alliance; empathy; client expectations)	Professional and practice issues	1004	2.93	.93	71.5
10	Psychotherapists reflecting on their internal experiences during therapy (e.g., feelings, thoughts)	Professional and practice issues	996	2.86	.99	67.3
11	Psychotherapists' well-being and self care	Professional and practice issues	987	2.86	1.03	66.3
12	Ongoing psychotherapy training	Therapeutic Interventions and processes	955	2.85	.92	68.0
13	Boundaries of the therapeutic relationship (e.g., therapist self-disclosure; unplanned contact outside of therapy)	Therapeutic interventions/processes	959	2.81	.96	65.7
14	Barriers to client access to psychotherapy (e.g., cultural, linguistic, economic, diagnostic)	Professional and practice issues	975	2.77	.99	61.8
15	Psychotherapists' need for and use of professional development to improve their practice	Professional and practice issues	992	2.76	.93	64.9
16	Effects of psychotherapy on changes in the brain	Therapy outcomes	953	2.76	1.06	64.1
17	Client symptoms and characteristics that affect a clinician's decisions about the psychotherapy	Therapeutic inputs	971	2.75	.88	63.7
18	Therapists' training, background, and personal characteristics that influence the psychotherapy	Therapeutic inputs	956	2.75	.95	62.4
19	Psychotherapists' knowledge and use of research to inform their practice	Professional and practice issues	996	2.72	.94	60.9
20	Collaboration between psychotherapists and other professionals	Therapy outcomes	957	2.71	.93	61.9
21	Combining medications with psychotherapy	Professional and practice issues	977	2.66	1.02	59.8
22	How to prepare clients for psychotherapy	Therapeutic inputs	959	2.64	.93	60.1
23	Real-world applications of manual-based interventions	Professional and practice issues	1003	2.62	1.19	59.5
24	The effect of mental illness stigma on whether clients seek and/or receive psychotherapy	Professional and practice issues	984	2.57	1.04	54.2
25	Combining adjuncts to psychotherapy (e.g., physical exercise, bibliotherapy)	Therapy outcomes	953	2.56	1.00	55.1
26	Psychotherapists' ability to work with clients from diverse backgrounds	Therapy outcomes	945	2.52	.94	53.2
27	How psychotherapy is integrated in inter-professional settings	Professional and practice issues	974	2.45	.99	50.3
28	The use of adjuncts to psychotherapy (e.g., physical exercise, bibliotherapy)	Professional and practice issues	971	2.43	.99	48.6
29	Cost-effectiveness of psychotherapy	Professional and practice issues	1006	2.42	1.02	48.3
30	How to provide psychotherapy to clients who have different characteristics from the therapist (e.g., culture, gender, sexual orientation)	Therapeutic inputs	961	2.41	.96	47.5
31	Regular standardized client self-report and feedback	Therapy outcomes	964	2.39	1.09	48.2
32	Stigma related to mental illness	Therapy outcomes	945	2.36	1.01	43.4
33	Matching therapy or therapist to client characteristics	Therapy outcomes	949	2.30	1.01	41.9
34	Regular standardized client self-report and feedback	Therapeutic interventions and processes	963	2.30	1.06	44.3
35	Incorporating new technologies in psychotherapy and effects on outcomes	Therapy outcomes	958	2.30	1.04	43.9
36	New technologies in psychotherapy	Therapeutic interventions and processes	949	2.28	1.06	43.1
37	Training other healthcare providers in basic psychotherapy skills (e.g., empathy, active listening)	Professional and practice issues	974	2.26	1.10	42.7
38	Psychotherapists' use of regular standardized client self-reports and feedback to track progress	Professional and practice issues	1004	2.23	1.08	41.8
39	Using manualized psychotherapies	Therapy outcomes	954	1.98	1.12	32.7

Table 2 (*continued*)

Rank	How important is it to you to have practice-based research on:	Survey major category	*N*	*M*	*SD*	% rated ≥ 3
40	Adherence to manualized treatments	Therapeutic interventions and processes	964	1.81	1.06	25.3
41	The practice of matching client and therapist characteristics (e.g., based on culture, gender, sexual orientation)	Professional and practice issues	982	1.80	1.03	23.1

Note. Items were rated on a 5-point scale: 0 (*not important*), 1 (*slightly important*), 2 (*moderately important*), 3 (*very important*), and 4 (*extremely important*). Items in the Therapeutic Interventions and Processes major section had the stem: "How important is it to you to have practice-based research on the effects of the following on psychotherapy processes." Items in the Therapy Outcomes major section had the stem: "How important is it to you to have practice-based research on the effects of the following on client outcomes."

To guide the interpretation of this rank ordering of 41 research areas important to clinicians' practices we conducted a principal components analysis (PCA) of item ratings in order to reduce the data. We chose PCA instead of an exploratory factor analysis because primarily we were interested in reducing our data to a smaller number of manageable components to aid in interpreting the survey findings; we were not primarily interested in defining factors that were representative of the population of research themes. We used a Promax rotation, identified components with eigenvalues $>$1.0, and considered the largest loading items across components that loaded $>$.40 as belonging to a component. Initially, 11 components emerged with eigenvalues $>$1. Component 10 had an eigenvalue of 1.01 and only two loading items ("combining medications and psychotherapy" and "effects of psychotherapy on the brain"), and component 11 had an eigenvalue of 1.00, and only one loading item ("cost effectiveness of psychotherapy"). Because components with very few items are not as reliable as multi-item factors, we chose to keep the nine interpretable components that accounted for 60.66% of the variance in the original PCA. In addition, 5 of the 41 items did not load $>$.40 on any component. We named the components (ordered by eigenvalue size): Therapeutic Relationship/Mechanisms of Change; Barriers and Stigma; Technology and Adjunctive Interventions; Progress Monitoring; Treatment Manuals; Training and Professional Development; Therapist Factors; Matching Client to Therapist or Therapy; and Client Factors. Coefficient alphas for these components ranged from .69 to .85, indicating adequate to good internal consistency. We then calculated the means of the items that loaded $>$.40 on each component, and used these means to rank order the components. The components, component ranking, items within each component, original item ranking, and component means and standard deviations appear in Table 3. Rank ordering of the components from highest to lowest were—(a) Therapeutic Relationship/Mechanism of Change, (b) Therapist Factors, (c) Training and Professional Development, and (d) Client Factors. The (e) Barriers and Stigma component was in the middle of the rankings. The lowest ranking domains were—(f) Technology and Adjunctive Interventions, (g) Progress Monitoring, (h) Matching Clients to Therapy or Therapists, and (i) Treatment Manuals.

Postsurvey Focus Groups

Postsurvey focus group discussions were geared toward interpreting the survey findings. Focus group members were generally not surprised by the highly ranked research areas (i.e., Therapeutic Relationship/Mechanisms of Change, Therapist Factors, Training and Professional Development, and Client Factors). To quote participants in the focus groups: "These items speak to what clinicians think first and foremost," that the top items are ". . . where therapists struggle the most," and that these domains represent ". . . core competencies that are most applicable across most clients." The high rating of professional development items may indicate that ". . . therapists want to know what will make them a better helper."

Some speculated that the general community of psychotherapists may not be as aware of the utility of progress monitoring, and this may have led to lower ratings of these items. Other clinicians in the focus groups indicated that ". . . monitoring may be perceived as interfering" with the therapeutic relationship. Further, some focus group participants indicated that clinicians may perceive progress monitoring as not providing enough specific information about effective interventions for a client who is not doing well. Similarly, focus group members suggested that ". . . manuals create a distance in the relationship" which they felt was antithetical to developing a bond with the client. Focus group participants also indicated that technology ". . . represents a significant challenge," as it stretches the boundaries of the therapeutic relationship when therapist and client "contacts" extend beyond the therapy hour. On the other hand, focus group participants saw the use of technologies to deliver therapy as important for creating greater accessibility for clients who live in rural areas, for those who have disabilities that limit mobility, and for younger clients who are more comfortable with this mode of communicating.

The general comments regarding the low ranking of the Matching Client to Therapist or Therapy component can be summed up by one focus group member's comment: "You can't control who walks in (to your office), and you can't change yourself. So basically, it's an issue that you have no control over anyway." Also, "therapists may feel that they can relate to any client," and so the issue of matching client and therapist may not have been perceived as relevant to survey respondents.

Several postsurvey focus group members were disappointed by the low ratings for items related to barriers to accessing psychotherapy and mental health stigma. Participants suggested that the low ratings may not be related to lack of concern about access, but rather that clients who are already in the therapist's practice did not experience problems accessing treatment. Focus group participants felt that lower ratings for stigma items may represent a phenomena of ". . . preaching to the converted." That is, psychotherapists generally may not feel negatively toward those who need their help for mental health problems.

Table 3
Rankings by Item Means (M) of Principal Components of Survey Items

Rank	Component	Rank of loading survey items	*N*	*M*	*SD*
1	Therapeutic relationship/ mechanisms of change	1. Understanding mechanisms of change 2. Therapeutic relationship (effect on outcomes) 5. Problems in the therapeutic relationship (alliance ruptures/repairs) 9. Common factors across therapies (alliance, empathy, expectations) 13. Boundaries of the therapeutic relationship	960	3.10	.63
2	Therapist factors	4. Reflection to improve own practice 10. Reflecting on own internal experiences (thoughts, feelings) 11. Self care and well-being 19. Knowledge and use of research to inform practice	1000	2.88	.71
3	Training/professional development	8. Psychotherapists training or professional development (effect on outcomes) 12. Ongoing psychotherapy training on process of therapy 15. Professional development to improve practice 20. Collaborations between therapists and other professionals	930	2.85	.74
4	Client factors	6. Tailoring psychotherapy to client motivation, expectations 17. Client symptoms and characteristics and effects on therapist decisions 22. Preparing clients for psychotherapy	940	2.80	.70
5	Barriers and stigma	14. Barriers to accessing psychotherapy (culture, language, diagnosis) 24. Effects of mental illness stigma on seeking or receiving therapy 32. Mental health stigma (effects on outcomes)	917	2.57	.86
6	Technology and adjunctive interventions	25. Combining adjuncts to psychotherapy (effects on outcomes) 28. Use of adjuncts to psychotherapy 36. New technologies (effects on the process) 35. Incorporating new technologies (effects on outcomes)	960	2.39	.83
7	Progress monitoring	31. Progress monitoring (effects on outcomes) 34. Progress monitoring (effects on process) 38. Standardized client self-reports and feedback to track progress	942	2.31	.97
8	Matching client and therapist or therapy	30. Providing therapy to clients with different characteristics from therapist 33. Matching client to therapy or therapist (effects on outcomes) 41. Practice of matching client and therapist characteristics (e.g., gender, culture)	919	2.17	.81
9	Treatment manuals	23. Real-world applications of manual-based interventions 39. Using manuals (effects on outcomes) 40. Adherence to manuals (effects on process)	938	2.14	.98

Note. Items within each component had a loading >.40.

Two potential reasons identified by postsurvey focus group members for the lower rankings of components like Technology and Adjunctive Interventions, Progress Monitoring, and Treatment Manuals could be tested quantitatively. First, participants in both focus groups suggested that the mean age of the survey sample, $M = 49.00$, $SD = 13.36$, meant that almost half of participants were over the age of 50 and so may not be as comfortable with the use of technology to assist therapy. Second, two thirds of the survey sample indicated a primary therapy orientation that was not cognitive–behavioral therapy (CBT), behavior therapy (BT), or dialectical behavior therapy (DBT), and the perception in the postsurvey focus groups was that those who did not practice according to these orientations may not be as comfortable with manualized therapies or progress monitoring. To test these possible reasons for lower rankings, first we correlated survey respondent age with each of the component mean ratings. Given that the large sample size could result in statistically significant associations despite small effects, we interpreted effect sizes expressed as correlation coefficients (medium effect $r \geq .30$, large effect $r \geq .50$) or Cohen's *d* (medium effect $d \geq .50$, large effect $d > .80$). The correlations between age and ratings for Technology and Adjunctive Interventions, $r(736) = -.09$, Progress Monitoring, $r(736) = -.07$, and Treatment Manuals, $r(736) = -.20$, were negative but small in size. We then examined the effect sizes for mean differences between those reporting CBT, BT, or DBT versus those reporting other primary orientations for these component ratings. For Technology and Adjunctive Interventions (CBT/BT/DBT: $M = 2.58$, $SD = 0.71$; Others: $M = 2.27$, $SD = .86$), the effect was small, $d = .36$; for Progress Monitoring (CBT/BT/DBT: $M = 2.61$, $SD = 0.79$; Others: $M = 2.12$, $SD = 1.01$), the effect approached medium, $d = .49$; and for Treatment Manuals (CBT/BT/DBT: $M = 2.62$, $SD = 0.78$; Others: $M = 1.85$, $SD = 0.97$), the effect size for the difference was large, $d = .80$. These findings indicated that those who reported CBT, BT, or DBT as primary orientations rated these components more highly than those who reported other theoretical orientations as primary. However, when the nine domains were separately rank ordered for those who indicated CBT, BT, or DBT as primary orientations, Technology and Adjunctive Interventions, Progress Monitoring, and Treatment Manuals were still ranked among the bottom five of the nine domains. The top four domains for those who listed CBT, BT, or DBT as primary orientations continued to include Therapeutic Relationship/Mechanisms of Change, Client Factors, Training and Professional Development, and Therapist Factors.

Discussion

We conceptualize the gap between psychotherapy research and clinical practice in terms of KTE (Graham et al., 2006). In other words, we see this divide as an interaction between: (a) researchers' tendency not to engage clinicians and not to use clinicians' wealth of knowledge to inform their research, and (b) clinicians' tendency not to use research findings to improve client outcomes. We suggest psychotherapy PRNs (Castonguay et al., 2013) as a means of KTE in which clinicians are brought into the research enterprise from the outset in part to define research priorities. Using a PAR framework (Macaulay et al., 1999; Jones & Wells, 2007), we conducted focus groups of clinicians interested in practice-based research in psychotherapy. From those groups we gleaned 41 research areas that we turned into survey items that were completed online by >1,000 participants. These 41 domains represent common themes of psychotherapy research and areas of particular interest to clinicians and their practices. We then ran two postsurvey focus groups of clinicians to help us to interpret and understand the findings.

Top-rated items and research domains that clinicians indicated were important to their practices were Therapeutic Relationship/Mechanisms of Change, Professional Development, Therapist Factors, and Client Factors (Tables 2 and 3). Quotes from the postsurvey focus groups suggested that these top-rated domains represent issues that are immediately relevant to what is occurring in the room between therapist and client. That is, clinicians are keen to see more research on: what to do with a particular client in order to create the conditions for change, the facilitating or impeding effects of therapist's internal experiences, client factors that affect the process and outcome of therapy, creating and maintaining a therapeutic relationship, and the effects of professional development and training.

Lowest ranking themes were related to—Technology and Adjunctive Interventions, Progress Monitoring, Manuals, and Matching Clients and Therapists. Postsurvey focus groups suggested that these research domains may have been perceived by clinicians as externally imposed agendas that impinge on the therapeutic relationship and are distant from primary concerns of therapists related to mechanisms that advance the process of therapy. The relatively lower ratings for Barriers and Stigma may reflect a tendency among psychotherapists toward thinking of therapy from a single service provider perspective. However, from the public health perspective, barriers to accessing psychotherapy and mental health stigma are much more important, as they reduce patients' likelihood to seek treatment and to remain in therapy (Corrigan, 2004).

The most discussion in the postsurvey focus groups was generated by the relatively low ranking of progress monitoring items. Clinicians in these focus groups were aware of progress monitoring research. However, as some have indicated, therapists in the general community may not be aware of the usefulness of progress monitoring (Ionita & Fitzpatrick, 2014). Similarly items related to the use of manuals may have been ranked lower likely due to therapists expecting a negative impact of manuals on the therapeutic relationship and the perceived limited utility of manuals. The latter is consistent with research indicating that level of adherence to treatment protocols is not always associated with enhanced client outcomes (Webb, DeRubeis, & Barber, 2010). On the other hand, some focus group participants stated that they were exposed to manuals during their training, and that they valued them sufficiently to routinely incorporate aspects of manuals in practice when appropriate. The findings suggest that more needs to be done to provide clinicians with opportunities to learn about the results of research on topics such as progress monitoring. The data on progress monitoring are extensive and based on many thousands of clients, and many of the progress monitoring studies are practice-based studies, so they have direct relevance to clinical practice (Lambert & Shimokawa, 2011).

Some postsurvey focus group members suggested that the average age of survey respondents or their theoretical orientation may have resulted in items on technology, progress monitoring, and manuals being rated lower. However, as indicated, age was not highly correlated with these items. Clinicians indicating CBT, BT, or DBT as primary theoretical orientations did rate progress monitoring and treatment manuals more highly than those indicating other primary theoretical orientations. However, despite this finding, research on progress monitoring and manuals continued to be ranked among the lowest research themes for those with a CBT, BT, or DBT orientation.

Limitations

One could argue that the survey sample, although large, is not representative of the community of those who practice psychotherapy. Most of the participants practice in Canada, and almost 60% were psychologists. However, average age of the sample (49 years), the proportion of women (66.8%) and White participants (78.6%), and distribution of theoretical orientations is very similar to previous surveys of psychologists in the United States (Cook, Biyanova, Elhai, Schnurr, & Coyne, 2010; Norcross, Karpiak, & Santoro, 2005). Nevertheless, the generalizability of the findings could be limited to this sample, and so interpretations of the findings should be made with some caution. Repeating the survey with a large sampling of therapists in the United States, for example, may help to extend the external validity of these findings. Also, the original 41 items gleaned from 10 focus groups may not be representative of all research domains that clinicians believe to be important to their practice. Clinicians who completed the survey were given the opportunity to indicate research areas important to their practice that they felt were not represented in the survey. Of the total sample, 400 provided a text response in this survey field. For the most part many of these areas fit within the nine domains identified by the principal components analysis of our survey items (e.g., client factors, therapist factors, mechanisms of change). However, other areas that respondents indicated were not in the survey included research on specific treatment methods (e.g., cognitive–behavioral therapy, psychodynamic therapy, emotion-focused therapy, sex therapy, hypnosis, etc.), specific modalities of therapy (e.g., family therapy, couple therapy, group therapy), professional practice issues (e.g., effects of professional standards, ethical issues), and long-term outcomes of psychotherapy.

Conclusions

The 41 categories gleaned from presurvey focus groups of clinicians and that made up the survey items were representative of psychotherapy research topics that appear in most major journals. This may indicate that clinicians are aware of these research domains and that these areas are in some way relevant to the everyday practice of psychotherapy. The relative ranking of these domains (Tables 2 and 3), the clear separation of level of consensus on the importance of the top-ranked versus bottom-ranked items (see Table 2), and the consistency of the rankings across primary theoretical orientations, suggest that clinicians value some of these areas above others. Psychotherapists appear to be primarily interested in research that speaks to what occurs within themselves and within the therapeutic relationship, and they have an interest in what their clients bring to the therapeutic encounter. One could argue, as did a number of the postsurvey focus group participants, that these research domains represent proximal factors with which the therapist has some immediate influence or control. Many of the lower rated domains (e.g., technologies, progress monitoring, manuals, matching) may be perceived as driven by factors external to the therapist—client dyad (e.g., by researchers, third party payers, agency administrators). Such research themes may be perceived by therapists with suspicion and responded to with some resistance.

Without the ability to translate research into action, psychotherapy research itself has little utility and clients will not benefit from what has been found in the research. There is substantial research in each of the categories identified in this study, except possibly for the domain of professional development in psychotherapy (Hill & Knox, 2013). This raises questions of whether survey respondents were aware of this research or whether they felt that the research did not fully address their clinical needs. Regardless of the answers to these questions, it is likely that, without clinician input and collaboration, some of the barriers to translating these lines of research into practice will remain. As reported by Tasca et al. (2014), clinicians' attitudes toward psychotherapy research, their perceived control over the research and practice, and the social norms within which they practice are each unique predictors of clinicians' intent to use research to inform their practice. Changing clinician attitudes, perceived behavioral control, and social norms may require a new type of collaborative relationship in which psychotherapists have a substantial say in what is researched, how the research is conducted, and how the knowledge is disseminated.

Results of the current study suggest a number of approaches to integrating clinicians into research programs. First, clinicians may be more likely to engage in a collaborative partnership with researchers if the research focuses on mechanisms of change, managing the therapeutic relationship, addressing the internal experience of the therapist, and client variables that promote or hinder change. Based on the high ranking of professional development items and comments from focus group members, clinicians are more likely to want to participate in such research if it involves a component of continuing education and professional development research. Second, conducting research on topics such as the use of technologies, progress monitoring, client/therapist/treatment matching, and treatment manuals will more likely be met with skepticism by clinicians at the outset. Collaborations in these areas of research may require more careful planning and flexibility by researchers. In order to engage clinicians in these research areas, researchers would do well to have an extended dialogue about the benefits and costs of these research areas to clinicians and their clients. For example, as suggested by some focus group members, it is possible that clinicians may not be aware of the benefits of progress monitoring. These clinicians may have to pilot test the process of progress monitoring with a few clients to evaluate its impact on the therapeutic relationship before they will engage in the research or employ the method in everyday practice. Qualitative coding of interviews of clinicians who participate in such practice-based research may shed light on the acceptability and intention to use progress monitoring procedures in the future.

The findings may also have implications for training. As indicated, younger psychotherapists may be more likely to use research on progress monitoring, but the association between age and ratings of this research area was modest. Given the impressive research on progress monitoring and the impact on client outcomes (Lambert & Shimokawa, 2011), training programs may wish to emphasize the use of progress monitoring throughout one's career, and the routine use of progress monitoring in supervision of trainees. This may encourage younger therapists to actively use these methods in their practice. There are indications that this is already happening in professional psychology training programs (Overington, Fitzpatrick, Hunsley, & Drapeau, 2014; Ready & Veague, 2014) and internships (Mours, Campbell, Gathercoal, & Peterson, 2009; Overington, Fitzpatrick, Drapeau, & Hunsley, 2014). On the other hand, the relatively high ranking of some themes may suggest that practicing therapists lack knowledge of existing research pertaining to fundamental aspects of the provision of psychotherapy, such as the relation between therapeutic alliance and treatment outcome (Horvath, Del Re, Fluckiger, & Symonds, 2011) and the nature of therapists' internal experiences that affect clinical decisions (Hayes, Gelso, & Hummel, 2011). Training programs may consider emphasizing the practice-based implications of these lines of research so that they have a greater impact on trainees' day to day clinical work.

As indicated at the outset, we systematically asked clinicians about their research priorities in part to inform psychotherapy research to be undertaken by PPRNet that will engage clinicians in practice-based research, which will in turn be translated into clinical practice. PPRNet will prioritize professional development research that emphasizes resolutions of problems in the therapeutic relationship, as this research likely will have a high probability of engaging clinicians and will contribute to the existing literature. Also, as our findings suggested, clinicians may not be aware of some of the current clinically relevant research in psychotherapy. To address this gap, the PPRNet provides its members with a monthly blog published on its Web site *www.pprnet.ca* that summarizes current research in psychotherapy and its practice implications.

Engaging clinicians, particularly in lower priority research domains, will involve changing clinicians' attitudes through trusting relationships and providing clinicians with a measure of control over the procedures and questions. This may be achieved by modifying research methods, developing networks of clinicians and researchers who value these areas of research, and negotiating flexible research protocols. KTE (Graham et al., 2006) is a relatively new way of conceptualizing the practice–research divide in psychotherapy. Traditional modes of knowledge dissemination have not been very successful in bringing research findings into the therapy room (Tobin et al., 2007; von Ranson et al., 2013). PRNs that emphasize values of engagement and community building (Jones & Wells, 2007) can be a means by which clinicians and researchers exchange knowledge and influence each other's work. The findings of this study provide direction for clinicians and researchers to negotiate new ways of collaborating and of practicing within their professions. The findings can be used by PRNs to capitalize on the substantial knowledge base of clinicians and researchers in order to produce actionable research that is more relevant and immediately applicable to clinical practice, and to improve patient outcomes.

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