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Title: How Usual is Treatment as Usual? Experienced Therapists' Reflections on Participation in Practice-based Research

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Abstract

Studies have shown that many clinicians are sceptical about research and hesitant about participating in research. In the present study we explored this issue by studying experienced therapists' reflections on their participation in practice-based research. Data were drawn from a practice-based research study at the University of Oslo, Norway. Twelve highly experienced therapists who had contributed to the study were invited to complete an open-ended questionnaire regarding their participation, and the text material was analyzed using a thematic analytic approach. Results indicated that research participation was experienced both as beneficial and demanding, and that being observed by others and following research procedures was experienced as affecting therapists' clinical work. We discuss these findings in relation to the distinction between 'treatment as usual' vs. 'treatment in a research context', and offer suggestions for steps to increase the clinical relevance and the ecological validity of psychotherapy research.

Keywords: ecological validity, practice-based research, therapist research participation, treatment as usual, object relations

Introduction

A number of studies in counselling psychology and allied disciplines, have found that typically, clinicians do not do research, is reluctant to participate in research, and do not find research findings useful in their clinical practice (Castonguay et al., 2010; Gyani, Shafran, & Myles, 2014; Morrow-Bradley & Elliott, 1986; Ogrodniczuk et al., 2010; Safran, Abreu, Ogilvie, & DeMaria, 2011; Stewart, Stirman, & Chambless, 2012). Several commentators have pointed to the gap between clinical practice and psychotherapy research (Castonguay et al., 2010), and have proposed various strategies for enhancing clinician engagement in research (McLeod, 2016). One possible explanation of this gap is the apparently opposing epistemologies behind these two endeavors. This is well illustrated in a study by Darlington and Scott (2002), in which clinicians labelled research as 'objective, hard, cold, scientific, factual, time-consuming, difficult, prestigious, tedious, expert', contrasted to clinical practice as 'subjective, busy, messy, difficult, soft, warm, pressured, flexible'. Many clinicians are sceptical about clinical research, especially outcome research and randomized controlled trials. Some find this kind of research too constrained to capture the complexity of clinical work and thus the findings irrelevant for their clinical practice (Busch et al., 2001; Leuzinger-Bohleber, Stuhr, Rüger, & Beutel, 2003).

Over the years, the focus on research and evidence-based practice has changed, and clinicians have become more obliged to pay attention to research (Midgley, 2012). There has also been a shift in research designs, opening up possibilities for qualitative research and more practice-near research. In searching for ways to build a bridge between research and practice, the use of practice-based research has expanded (Barkham, Hardy, & Mellor-Clark, 2010). Practice-based research refers broadly to 'non-experimental research, research by practitioners, research in naturalistic settings, and particular therapy research paradigms such as case-studies, process research and effectiveness studies' (Henton, 2012, p. 14). One context

in which practice-based research is conducted is the practice research network. A practice research network may be described as an infrastructure that encourages collaborations between practitioners and clinical scientists in the development and conduct of internally valid and clinically relevant research (Borkovec, Echemendia, Ragusea, & Ruiz, 2001; Castonguay et al., 2017; Fenton, Harvey, Griffiths, Wild, & Stuart, 2001; Henton, 2012). Several studies indicate that involvement in practice research networks increase clinician interest in and utilization of psychotherapy research (Castonguay et al., 2010; Henton & Midgley, 2012; Thurin, Thurin, & Midgley, 2012).

Related to these findings is the question about what clinicians find useful in psychotherapy research. In a study by Tasca et al. (2014) on Practice Research Networks they asked clinicians what they want from research. Their answers, ranked from the most to least important research themes, were: therapeutic relationship/mechanisms of change; therapist factors; training and professional development; client factors; barriers and stigma; technology and adjunctive interventions; progress monitoring; matching client to therapist or therapy; and, treatment manuals. These findings are a useful starting-point for considering how to integrate relevant questions with psychotherapy research objectives.

The scientist-practitioner model of training in clinical psychology and counselling psychology is predicated on the assumption that clinicians could be better practitioners by doing research (Overholser, 2010). However, relatively little is known about how engagement in research is experienced by clinicians delivering therapy in the context of collecting research data (Grafanaki, 2012). Several studies have suggested that research participation increased therapist interest in research and willingness to use research findings to inform their practice. For example, Henton and Midgley (2012) explored how participation in a large-scale RCT changed the therapists' attitudes toward outcome research. The five child psychotherapists interviewed found research participation transformative and experienced an increased

confidence, curiosity and open-mindedness toward outcome research. Similar findings were reported by Horneland et al. (2011) in interviews with group therapists who had taken part in an RCT. Thurin and co-workers (2012) conducted a survey to investigate conditions that encouraged clinicians to participate in a French practice research network. Elements that emerged as key to clinicians' positive involvement in research were: the implemented methodology (intensive case studies), relevant measures, the constant attention to the practicalities and the potential contribution of studies to clinical practice, the organization of work in peer groups, the training methods, the use of new information technologies and the sense of participation in a project that would support the profession. Participants did not report any negative impact of the research procedures on their clients. Rather, they experienced that research participation revitalized their clinical work, enabled them to specify clinical questions, facilitated discussions between peers that stimulated their reflection on patients, and raised theoretical issues.

Castonguay and co-workers (2010) explored psychotherapists' experiences of participating in a practice-research network. Thirteen therapists involved in the design and conduct of the PRN were interviewed about their experiences. The results showed that the psychotherapists described several benefits for themselves and their clients from participation (e.g., learning information that improved their clinical work), as well as some difficulties (e.g., time and effort required to integrate the research protocol into their practice). One of the authors' conclusions for future PRNs is that research has to be "clinically-syntonic", i.e., that it is impossible to fully distinguish whether the tasks performed are empirical or clinical.

Other studies have focused on the experience of clinicians around the impact of specific data collection procedures. Grafanaki (2012) interviewed six person-centered therapists about their experiences in participating in a longitudinal, systematic case study. The use of a Brief Structured Recall method and qualitative interviewing of the therapists were

reported as comprising important factors in promoting therapist reflexivity. In a study of psychoanalysts conducting brief psychodynamic therapy for panic disorder in adults, Busch et al. (2001) found that some research procedures interacted positively with psychoanalytic practice, for instance using the video camera in a psychoanalytic manner, as an opportunity to explore clients' fear of exposure. Audio or video recording of therapy sessions represents a method of collecting research data that may be perceived as highly intrusive. Studies of the use of recording in the context of training and supervision, have found that although such practices are perceived as threatening by some clients and therapists, the majority tend to learn to take recording for granted within a brief period (Briggie et al., 2016; Brown, Moller & Ramsey-Wade, 2013; Gelso, 1974; Gossman & Miller, 2012; Shepherd, Salkovskis, & Morris, 2009). A similar pattern was reported by a study of the views of clients and therapists whose interactions were being audio-recorded as part of a research study (Marshall et al., 2001).

Taken as a whole, research into clinicians' experiences of participating in research, suggests that clinicians generally view such activities as making a valuable contribution to their professional development and potentially enhancing of clinical work. However, knowledge around the impact of specific research procedures, and the effect of different research contexts, remains fragmented. The aim of the present study was to examine experienced therapists' reflections on their participation in practice-based research. Our research questions were: How do the therapists experience research participation? And, in what ways does research participation influence their therapeutic practice?

Method

Research design

A qualitative approach was chosen as the appropriate methodology for a study exploring the meanings of social phenomena as experienced by individuals themselves, in their natural context (Malterud, 2001, p. 483). Since our aim was to explore individual experiences of research participation, our approach was grounded within a phenomenological epistemology that emphasized everyday experience of reality (McLeod, 2001). To collect data on the therapists' experiences as research participants, we used a questionnaire where the focus was on their experiences, intentions and meaning making. This provided us with a relatively rich, qualitative, narrative text material as a source of hermeneutic knowledge. The researchers were in a continuous dialogue with the therapists throughout the project period, both through seminars and interviews, making it possible to establish a reflexive co-researcher relationship based on mutual confidence and trust. Data from the questionnaires were therefore rooted within a broader research context that enabled interpretive depth to be achieved. Within this general hermeneutical-phenomenological frame, we analyzed the data using a team-based approach to thematic analysis (Binder, Holgersen, & Moltu, 2012; Braun & Clarke, 2006; Moltu, Stefansen, Nøtnes, Skjølberg, & Veseth, 2017), as it offers a theoretically flexible approach for the analysis of a broad range of qualitative material, including texts.

Data and procedures

Data were drawn from an extensive practice-based research project called 'An intensive process-outcome study of the interpersonal aspects of psychotherapy', which explored psychotherapy in naturalistic settings and involved 18 highly experienced therapists, 48 of their clients, and several researchers (Rønnestad, 2009; Rønnestad et al., 2014). The project resembles many of the features of a practice research network, as it was based on an on-going collaboration between researchers and clinicians to ensure a design that was clinically relevant, as well as being minimally disruptive to day-to-day clinical practice. The

project brought together a number of elements that have been associated with successful therapy and best-practice psychotherapy research: a focus on *interpersonal process*; the collection of *continuous data* (i.e., from each therapy session); collection of data from *multiple perspectives*, that is, *both* from patient and therapist after each session, and digital recordings making external observation possible; a combination of *qualitative and quantitative* data; and the study of experienced therapists. The following inclusion criteria were set in the broader practice-based research project, and the therapists needed to meet all of them: (1) extensive experience as psychotherapists (i.e., a minimum of 15 years' post-degree); (2) specialists in either clinical psychology (authorized by the Norwegian Psychological Association) or psychiatry (authorized by the Norwegian Medical Association); (3) psychotherapy teachers, for example at universities and/or at post-graduate training; and (4) clinical authorship. The presumed expertise of therapists in the study was defined in terms of a combination of extensive clinical experience and the theoretical and reflective competence assumed to be acquired through academic activities (Rønnestad, 2009). All the psychotherapists had an independent private practice, and they were instructed to conduct "treatment as usual" with their clients in this project.

At the close of the practice-based research project, we wanted a more systematic feedback from the therapists on the project and their participation. The present study was thus introduced as an open invitation to the therapists involved, to reflect on their experiences as research participants after the therapies and data collection were completed. Although 18 therapists were originally included in the project, some were unable to take part in this last phase (one therapist was deceased; one was unable to participate in further research due to severe illness; two therapists withdrew from the project in an earlier phase - one withdrew because the client did not want to participate further, the other because of time pressure. They

have both permitted their collected data material to remain part of the database). This left us with 14 potential participants in the present study.

Participants. Twelve therapists responded (a response rate of 86 %), nine responders were women and three responders were men. The therapists were clinical psychologists (n = 11) and psychiatrists (n = 1), and they had practiced as clinicians for between 15 and 45 years. All participants had varied experience as clinicians, clinical teachers and supervisors, as well as authors of professional literature on psychotherapy. Forty-two percent were in academic positions with part-time practice and 58 % were in full-time independent private practice. Their theoretical orientation varied considerably both in major orientation and in additional influences from other therapy orientations. The majority of therapists was drawing on three to four theoretical orientations, and may be characterized as integrative therapists. A smaller number of therapists were predominantly psychodynamic or predominantly cognitive and systemic.

The research context and protocol. To contextualize the therapists' reflections on research participation, we will give a brief description of the overall practice-based research project. The therapies were part of the therapists' ordinary private practice, where the clients paid a low standard fee for their consultations, and therapy was mainly paid by public social security. The clients had actively sought therapy, and the therapies were open-ended. The research protocol included standardized process and outcome measures, session recordings, session evaluations, and interviews after treatment termination and at a follow-up stage. These measures and procedures are further described below.

The Working Alliance Inventory—Short Revised (WAI-SR; Hatcher & Gillapsy, 2006) is a measure of the quality of the therapeutic relationship. It was completed by client and therapist separately after sessions 3, 6, 12 and 20, and then at every 20th session, until just

after the last session. The Outcome Questionnaire (OQ-45.2; Lambert, Burlingame, Umphress, Hansen, Vermeersch, Clouse, & Yanchar, 1996) is an outcome measure of overall distress completed by the client after sessions 1, 3, 6, 12 and 20, and after this every 20th session, after the last session, at follow up after one year, and after three to four years. The Inventory of Interpersonal Problems (IIP-C-64; Alden, Wiggins, & Pincus, 1990) is a measure of interpersonal difficulties and was completed by the client on the same time schedule as the OQ-45.

In addition, all sessions were audio recorded. After every session the patient and therapist separately completed a modified version of the Helpful Aspects of Therapy form (HAT; Llewelyn, Elliott, Shapiro, Firth, & Hardy, 1988). The notes from the client were collected in sealed envelopes and therefore not accessible to the therapist.

After treatment termination, both client and therapist were interviewed about their experiences of and reflections on the therapy. The interview guide was organised around topics concerning the therapeutic process and helpful aspects of treatment. The client was also interviewed at three to four years follow up. The first and third authors, in addition to two colleagues in the research project, conducted the interviews.

In addition to these procedures, the therapists were invited to seminars where findings from the research project were presented and discussed, and where they had the opportunity to feed back on the project and to meet researchers and other participants.

Researchers. All five authors are researchers who also work as psychotherapists. They share an interest in facilitating integration between psychotherapy research and clinical practice. The first author is an Associate Professor and has 15 years' psychotherapeutic experience. Her theoretical orientation may be described as integrative, theoretically informed by psychodynamic, developmental, humanistic and cognitive approaches. The second author is

an Associate Professor and has 30 years' of clinical experience. Her theoretical orientation may be described as integrative, theoretically informed by humanistic, CBT and dynamic approaches. The third author is an Associate Professor in clinical psychology, and has been practicing as a clinical psychologist for 20 years. Her clinical orientation is based on the integration of theories and techniques from cognitive behavioral, phenomenological/existential, systemic, and language-based perspectives. The fourth author is an Associate Professor and has 16 years' of clinical experience. His theoretical orientation is primarily psychoanalytic. The fifth author is a Professor with 25 years' of clinical experience. His approach is pluralistic, informed by person-centered, cognitive-behavioral and narrative theoretical perspectives. All five authors participated in the data analysis.

Ethical Procedures. All ethics procedures in the larger practice-based research study (Rønnestad, 2009) were approved by the Norwegian Regional Committee for Medical and Health Research Ethics (National Region South-East). One important guiding ethical principle was to set up a naturalistic study, which meant that the collection of data should not be too intrusive or time-consuming for either therapist or client. Data were stored according to a license awarded by the Norwegian Social Science Data Services. The ethical procedures of the present study were covered by the overarching ethical approval and consents gained through the larger practice-based research project. However, this study's participants were asked for their further informed consent in relation to the specific research procedures for this study. Only the first author knew the identity of the participants; details about the therapists have been transformed to provide anonymity.

Data collection and analysis

The therapists were contacted by e-mail by the head of the project (first author), and asked to respond to a series of open-ended questions regarding their experiences as research

participants. In order to ensure diversity of responses, participants were instructed to write as freely as possible, and were encouraged to support their answers with examples, as well as to share critical reflections. The choice of written questionnaires as opposed to interview data collection was pragmatic, in order to reach all the therapists. The open-ended questionnaire covered the following topics: experience of research participation, being observed, selection of clients, the potential impact of research and formal procedures on therapy process and outcome, the experience of being interviewed about their treatments, and attitudes towards research.

The analysis was conducted in accordance with the principles of an inductive and semantic thematic analysis outlined by Braun and Clark (2006). Themes were identified in a 'bottom-up' inductive process from the data, and we were interested in the explicit (semantic) meanings of the data (Braun & Clark, 2006). We used a team-based structured approach to the analysis (Binder et al., 2012). The first four authors thoroughly read all the material individually to gain familiarity with participant experiences. The first author then independently conducted the initial coding and searched for potential themes. The team then met and worked together to revise and refine these themes and arrive at a consensus representation. Subsequently the fifth author was invited in as an auditor to critically review the themes and the process of analysis. The last step consisted of further categorization of the themes and selection of quotes to include in this article. Throughout the analytic process, the researchers continuously collaborated and discussed the material. Preliminary results from this study were also presented for the therapists at a seminar, and experiences and reflections were discussed in plenary. Even though these comments were not part of the data collection in the present study, the discussion was an opportunity for us to receive feedback from the participants on the results, in this way enhancing the trustworthiness of our analysis.

Results

Participants' accounts produced a meaningful story that captured an overall positive experience of participating in the practice-based research project, including its benefits and challenges. The qualitative analysis of the therapists' written responses identified three main themes, reflecting different ways in which research participation had impacted the therapeutic process: 1) Being observed - acting differently as a therapist; 2) The impact of research devices; and 3) Learning from participation. See Table 1 for the main themes and sub-themes.

Main theme 1. Being observed - acting differently as a therapist

Eleven of the therapists described how they were conscious of being observed (through audio recordings and questionnaires) in the beginning. Some of them forgot about the recorder after a while, although others found it distressing. What became evident through the analysis was that these research procedures were not neutral devices. Through these procedures, a third part was introduced into the therapeutic dyad. It was no longer two in the room, but three. The presence of a third part took different forms (i.e., the audio recorder, the schemas/questionnaires), and had different impact on the therapists. These may all be seen as psychologically meaningful objects. Some therapists experienced them as impeding the process, while others saw them as stimulating. We have identified two sub-themes, representing how the research devices and procedures affected the therapists. The sub-themes are labelled: *An imagined critical gaze*, and *A beneficial helper*.

1.1. ***An imagined critical gaze***. Through the research devices, the imagined researcher's gaze and evaluations became present in the awareness of six of the therapists. As therapist M said: "*I got more self-conscious – I looked at myself through potential researchers' gaze. That was disturbing*".

Especially when there were strains in the therapeutic relation or they experienced other challenges, some therapists described the potential observational gaze from researchers as distressing.

"*When there was standstill (i.e., in the process) a thought about an "external observational critical gaze" emerged – that had to be dealt with. I think I got conscious about being focused on structural aspects like goals and where we were in the process*" (Therapist L).

Some of the therapists commented on their role as experts, and how the external gaze was related to this: "*I am used to being observed from previous research projects, but there was also a disturbance there, and thoughts about being evaluated and not living up to the "expert role" emerged. This was in relation to a client who had quite severe problems and was not so accessible*" (Therapist O).

Therapist M talked about how she became more self-conscious in relation to being observed by researchers, and that this had impact on her therapist role. She said: "*I got more self-conscious, and self-critical. Not all the time, but I became more sensitive concerning if I said or did anything stupid, and spent more energy than usual thinking about mistakes. I could envisage some of the faces (i.e., researchers at the university) and think about their rolling eyes and things like that. I believe this stole some of the unconventionality that I usually experience as a therapist. I do also think that this self-consciousness sometimes made me intervene in ways that I usually don't do, and that I became "weaker" as a therapist – took less charge, maybe*"

The same therapist responded to this third part of a potentially critical observer: "*At some occasions I did somewhat "strange" things, which were in relation to being observed. As if there was a little devil inside, who made a self-fulfilling prophecy: "Now you should*

really be a bit stupid, now that you sit here and are anxious about being stupid…"I don't remember any examples, but I remember the feeling" (Therapist M).

All these excerpts illustrate how the process of audio recording introduced an imagined critical observer into the therapy room.

1.2 A beneficial helper. While the potential researcher's gaze disturbed some of the therapists, informants also reported that participation had a positive impact on their therapies. Six therapists experienced that being observed had a positive impact on their therapies. They spoke about being more focused, becoming more reflective, being more structured, and delivering shorter therapies, etc. One therapist said: "*I probably got more goal directed in these treatments than I usually am. I got more concerned about "what are we doing?" and "where are we going?" The reflection notes after every session helped me in relation to that. I believe, without knowing for sure, that these treatments got shorter, that is fewer sessions, than what is usual and typical for me*" (Therapist D). Likewise, Therapist N said: "*I did not feel like being observed, but I do believe that one gets more concentrated by participating in such a data collection*".

Main theme 2. The impact of research devices

The second theme is directly related to the research devices and procedures and how they affected the therapists. We identified two sub-themes: *Taking control over the devices to facilitate the alliance*, and *Being caught by the research procedures*.

2.1 Taking control over the devices to facilitate the alliance. Three of the therapists said that they used the research procedures explicit as part of the alliance work. One way of doing this was to create a "we/them"-distinction, where the client and therapist were bonding "against" the researchers. For instance, Therapist G said: "*We (i.e., the client and I) joked about the complications with the recorder. I think that contributed to bonding. We were in the same*

boat - somebody else should evaluate <u>us</u>. Retrospectively, I can say that when we already was

in an unusual situation, I used it deliberately in the alliance work".

Another example where the devices were used in alliance work was a therapist who

decided to turn off the recorder. The client talked about difficult topics from her childhood,

and asked if it was possible to turn off the recorder. Therapist E said: "*I turned off the audio*

recorder over a period of time with one client – and that was a turning point in this treatment.

In this respect one may say that the recordings meant something positive through the contrast

that occurred when it was turned off". (…) It became a turning point, maybe mostly because I

shared my experience about how the recordings disturbed me as well. Some of this woman's

problems were related to perfectionism and a belief that she wasn't important to other

people". According to the therapist, the act of turning the recorder off probably made the

client feel heard and valued by the therapist.

2.2   Being caught up in the research procedures. Six therapists talked about how they felt

that time and attention needed to be devoted to the research procedures, in ways that hindered

them in doing treatment as usual. For example, Therapist D said: "*I got caught up in the*

procedure that I should tell the clients that I did not read their responses on the

questionnaires, and assure them that the envelope was delivered straight to the researchers. It

made the completion of the questionnaires less important for the clients, I think. (…) It was

just like I followed a regime. I could not find any room to say that if they thought about

something after the session, when they completed the reflection note, they could bring it back

in the next session in a verbal manner. They could have used it as feedback if … this was

something that they thought that I ought to understand". For Therapist D, this aspect of the

research became an issue that concerned her, and around which she found it hard to arrive at a

satisfactory resolution.

Main theme 3. Learning from participation – how research influenced clinical practice

All participants reflected on how research participation influenced their practice and described how they developed new knowledge through participation. This included both learning about themselves as therapists and about research more generally.

3.1 Research participation as facilitating clinical work. Overall, all the therapists described research participation as a demanding, but positive experience. They described the experience of participating using adjectives including "good", "enjoyable", "stimulating", "interesting", and "exciting". Therapist H said: "*I have learned more about how psychotherapy research is experienced from the therapist's position. That it is demanding, but also rewarding to participate in a clinical research project*".

Several of the therapists talked about the design of the project as relevant and trustworthy, something that made participation significant for them: "*I am happy that I was invited to participate and I have learned a lot from the seminars we were invited to attend. I think it was very interesting to participate as a therapist in such a clinically relevant and proper research project*" (Therapist L). The excitement was also balanced by a challenge: "*It was meaningful in the way that I think this project is really important. It was challenging in the way that I found it hard to complete all the questionnaires. Often I thought of myself as a bad researcher who did not do my duty*" (Therapist C).

Eleven of the therapists highlighted the post-treatment interviews as valuable and interesting, giving new perspectives on own practice, raising their awareness, and promoting a more reflective stance. "*It was extremely useful and exciting, and it made me reflect on what I had done in a different manner than if I should just sit down and think about it by myself. I really appreciated it!*" (Therapist P).

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Some of them talked about the interview as something therapists in general would have benefitted from: "*It was great! For therapists working alone, it would have been really beneficial if somebody came and asked them questions about their specific cases at some occasions, especially when the therapies are coming to an end. I am a bit worried that experienced therapists in independent practice may be too relaxed. They may end up working with highly motivated clients that keep coming, who are satisfied by being met in a respectful way, but may be without sufficient efforts to enable them to reach their goals. (…) The interviewer was really good at asking questions about specific topics. She was very respectful, and in the aftermath I have thought that she could have been even more challenging*" (Therapist D).

3.2 Increased confidence in research

Nine therapists reflected on how research participation had increased their knowledge about psychotherapy research. Five talked about an improved confidence and trust in research findings. In particular, they reported a heightened awareness of the therapeutic alliance and how to monitor the psychotherapy process. For example, Therapist H said: "*I have learned something directly from participation and something from the results that have been presented. Especially the importance of alliance work in the first sessions has become very clear. And the necessity to keep an overview – like one does in supervision – has been even clearer*". Therapist G said: "*I have got more knowledge and insight in different aspects of the therapy process – especially what makes it possible to evaluate it and discuss it in a systematic manner*".

In many ways Therapist F summarized a major theme emerging from these results when she commented on how her attitude towards psychotherapy research had changed as a consequence of participation: "*Yes, I have been even more convinced about how difficult it is*

to treat clients "as usual" in a research setting. Nevertheless, I really believe that we learn

something new through projects like this".

Discussion

Within the present study, therapist reports of both learning from participation and experiencing increased confidence in research can be regarded as broadly supporting the findings of previous research into therapist participation in research (Castonguay et al., 2010; Henton & Midgley, 2012; Thurin et al., 2012). The therapists considered the study to be clinically relevant, the research procedures (e.g., questionnaires, audio recordings, session evaluations, interviews) to be meaningful and manageable and not too intrusive in their regular clinical work, and the interviews and seminars to be inspiring and fruitful. They underlined the value of a professional dialogue and of being listened to. To be able to reflect on their own practices and to explain the reasons for their interventions, as well as to reflect upon the therapy process as a whole seemed to confirm their position as senior experts. They said that they appreciated the opportunity to challenge their own clinical choices and reflections about theoretical issues.

A distinctive theme that emerged in the findings of the present study relates to the way in which the practice-based research setting became an arena for learning in an area that linked to the overall aims and theoretical framework of the larger practice-based research project. This phenomenon may be captured by the concept of *researcher allegiance*, coined by Luborsky et al. (1999) who demonstrated its significant impact on the effect size of outcome. Considerable evidence exists that researcher theoretical allegiance is significantly related to the effect size of outcome (Dragioti, Dimoliatis & Evangelou, 2015; Munder et al., 2011, 2013). Different explanations for the allegiance effect have been suggested (Berman & Reich, 2010; McLeod, 2010). What emerged in the present study was the degree to which the therapists describe their learning from research participation, and how much this impacted on

their further practice. The theoretical background for the practice-based research project is the large body of research documenting the impact of common factors, and the significance of the therapeutic alliance. Our broader practice-based study was designed to explore how experienced therapists do alliance work (i.e., the concrete actions and strategies that they employ to build an alliance with the client). As researchers, we are interested in these topics, and even though we did not explicitly teach the therapists a model, the research project seems to have been formative in respect of how therapists involved in the practice-based study thought and talked about their clinical practice. In the context of the opportunity to reflect afforded by the present study, several therapists said that they became more aware of the early alliance work, more focused on goals and tasks, and more likely to monitor the alliance in new ways. As such, one could say that the overall practice-based research project, through adopting a formative and theory-building approach that engaged the interest and imagination of participating therapists, had the effect of impacting therapeutic work in ways that might lead to the conclusion that these therapies did not entirely represent "treatments as usual".

In a similar way, a further critical finding was that, as in Busch et al. (2001), the research procedures and devices were not something neutral that were merely added on to the therapeutic setting. Rather, the research procedures and devices became part of the therapeutic interaction and potentially shaped how aspects of the processes of the therapy were carried out. The research devices seemed to represent inner psychological objects that the therapists related to and which affected their work. To understand this phenomenon, object relations theory (Fairbairn, 1952; Freud, 1917; Klein, 1932; Winnicott, 1953) may be relevant. An *object* is defined as something that stands for a representation of a human being, and an *object relation* is a representation of a self that is interacting with a represented object. This interaction is bound by affects. The objects are not directly observable, and have to be interpreted (Gullestad & Killingmo, 2013).

In the present research setting, the research devices – such as questionnaires and audio recorders – can be interpreted as activating fantasies of different kind of objects, with different qualities. For some of the therapists, these objects were appreciative and stimulating, for others they were worrisome and critical. For some of the therapists these were fantasies of concrete persons ("Professor X") or specified actions in researchers (rolling eyes), for others they were more diffuse fantasies of a group attitude (such as "the researcher team at the university"). For some therapists the devices seemed to represent more demanding objects, which made them intervene differently than they usually did in their therapeutic work. For example, the therapist who experienced that she became a "weaker therapist" due to the research setting, which seemed to actualize fantasies about critique and devaluations from researchers. For others, the devices seemed to represent more beneficial objects, helping them to stay focused, being more attentive to the process, and increasing their reflexivity. This is in line with the findings of Busch et al. (2001) where therapists integrated research devices into the therapeutic procedures (e.g., making alliances "we against them", talked about a common destiny, showed vulnerability by not managing the technical devices), and as such utilized the research setting as a clinical tool. In these ways, the objects were formative for the experienced therapists' clinical work.

Therapist reports, in the present study, of the experience of being recording leading to heightened self-awareness due to the imagined threat of critical judgement by colleagues, were similar to findings reported by Shepherd et al. (2009) in the context of recordings made for clinical supervision. We suggest that an object relations perspective affords a more nuanced understanding of this phenomenon, which opens up new possibilities for both therapists and researchers to learn from this process.

We found that the ascribed expert role disturbed some of the therapists, as if they felt pressure to live up to this status. This finding contributes to a growing body of research that

suggesting that professional self-doubt (Nissen-Lie, Monsen, & Rønnestad, 2010), and professional self-doubt allied to a positive self-image (Nissen-Lie et al., 2015) represent general therapist qualities that are associated with good outcomes.

Based on the implications drawn from our results, a central question has emerged, relevant for the practice-based research - how to define "treatment as usual", in the context of research that incorporates investigative procedures and devices into routine practice. The idea of treatment as usual is commonly used in psychotherapy research to refer to psychotherapies conducted outside a research context. What the present findings indicate is that a clear-cut binary distinction between treatment as usual and treatment in research settings is not warranted. Research procedures may impact treatment in such a way that the meaning of "as usual" may be obscured. At one end of a continuum is therapy practice that is minimally research-informed. At the other extreme are collaborative situations where researchers and therapists actively work together to develop and implement research ideas within routine practice settings (see, for example, Fernández-Alvarez et al., 2015; Newsom et al., 2011). Somewhere in the middle exists a more familiar research scenario in which the researcher designs a study, and recruits therapists to take part. Our own project could be regarded as existing at the collaborative end of such a spectrum. It seems significant to us that even in such a situation, therapists describe their work with clients as influenced by unresolved internalizations or fantasies of the imagined presence of the researcher. It would be valuable, in future research, to explore this phenomenon in more detail, for example in relation to the gradual working-through of such dilemmas, and the kinds of supervisory support or training that might facilitate such a process.

Limitations

A number of limitations of the present study ought to be mentioned. First, we used written responses to explore the therapists' experiences. There are reasons to believe that other topics could have evolved if we had interviewed the therapists, individually or in focus groups. In an interview setting, we could have guided the therapists to a larger extent, explored nuances further, and asked for more examples. On the other hand, it is possible that our participants may have felt freer to express their anxieties about research participation, compared to the context of a face-to-face interview with a member of the primary research team. Second, the therapists' text-responses were not anonymous. The head of the project (first author) contacted the therapists by e-mail, informed them about the project, sent them the reflection note, and received their replies. Consequently, the therapists knew who was going to read and analyze their responses and conduct this study. We thus cannot rule out that they replied to these questions in a selective way. As far as we can see, this could possibly happened in an interview context as well, and is hard to rule out when therapists are involved in and take part as collaborators in the project. Third, participants provided retrospective accounts, and may have been able to generate more comprehensive and detailed descriptions if they had recorded their experience (e.g., in a diary) on a regular basis over the course of carrying out therapy with research clients. Finally, it is necessary to acknowledge that some of the therapists in the present study held various types of university affiliation and had completed research at Doctoral level, and as a result were familiar with research procedures. It is possible that a less research-friendly group of therapists might have reported different reactions.

Conclusion

On the whole, the results of the present study underscore the importance of the idea that therapists are active collaborators, not mere producers of data (Castonguay et al., 2010). The cooperation with therapists as influential participants in psychotherapy research may

increase motivation for participation and strengthen the feeling of relevance of research for the therapist. We suggest that these are key elements to increase the ecological validity in psychotherapy research. The findings of this study are a reminder of the significance of context for understandings generated in practice and in research. Overall, the therapists experienced their participation in practice-based research as beneficial, both directly into their clinical work, and on a general level of evolving new knowledge. However, in the context of practice-based research, the idea that therapy or treatment is "as usual" is somewhat paradoxical. In the present study, the therapists suggested they were affected by being observed by another professional while conducting therapy in the context of practice-based research. Some of them possibly performed better, other worse, than they usually do. To be observed or follow a defined research procedure is different from being as usual. Moreover, what became evident was that research participation also is personal, and therapist's vulnerability and professional self-doubt may interact with observation by others, and consequently affect how therapies are conducted. It is reasonable to believe that this is a topic also in other research designs and settings. The findings indicate that treatment as usual cannot be seen as something separate from the research context. All research procedures and research questions will probably affect the respondent. Further research should add focused interviews to explore the present topics, and also include participants from other research settings, such as experimental designs, to examine potential differences in participants' responses, and to elaborate on the impact on the clinical practices of counselling psychologists, psychotherapists and allied disciplines.

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Table 1.

Main themes and sub-themes. The numbers of participants who contributed to each theme are provided in parenthesis.

Main themes	Sub-themes
1. Being observed - acting differently as a therapist (11)	
	1.1 An imagined critical gaze (6)
	1.2 A beneficial helper (6)
2. The impact of research devices (9)	
	2.1 Taking control over the devices to facilitate the alliance (3)
	2.2 Being caught up in the research procedures (6)
3. Learning from participation – how research influenced clinical practice (12)	
	3.1 Research participation as facilitating clinical work (12)
	3.2 Increased confidence in research (9)