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A Qualitative Investigation of Practicing Psychologists' Attitudes Toward Research-Informed Practice: Implications for Dissemination Strategies

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Abstract

This article presents the results of a qualitative analysis of interviews with 25 psychologists in independent practice, investigating everyday treatment decisions and attitudes about treatment outcome research and empirically supported treatments (ESTs). Clinicians noted positive aspects about treatment outcome research, such as being interested in what works. However, they had misgivings about the application of controlled research findings to their practices, were skeptical about using manualized protocols, and expressed concern that nonpsychologists would use EST lists to dictate practice. Clinicians reported practicing in an eclectic framework, and many reported including cognitive-behavioral elements in their practice. To improve their practice, they reported valuing clinical experience, peer networks, practitioner-oriented books, and continuing education when it was not too basic. Time and financial barriers concerned nearly all participants. Clinicians suggested they might be interested in ESTs if they could integrate them into their current frameworks, and if resources for learning ESTs were improved.

Keywords

empirically supported treatments; science-practice gap; private practitioners; dissemination; decision making in psychotherapy

For decades the alliance between psychotherapy researchers and practitioners has been an uneasy one. The recent emphasis on evidence-based practice (EBP) has further highlighted this complex relationship. As defined by the Institute of Medicine, EBP is “the integration of

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best research evidence with clinical expertise and patient values” (Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000).¹ At the heart of the controversy of EBP in psychology is the question of best research evidence: what qualifies as evidence, the utility of the evidence, and how much the evidence should inform or dictate treatment (Stiles et al., 2006). Not surprisingly, empirically supported treatments (ESTs; Task Force on the Promotion and Dissemination of Psychological Procedures, 1995), which represent one effort to define the best research evidence, have been the subject of intense scrutiny.

Presuming that psychotherapy researchers want to promote the use of the research evidence through EBP and ESTs, it is important they understand practicing clinicians and their attitudes toward research products (Lomas, 1993). What do practicing clinicians think about ESTs and EBP? Much has been written about supposed reasons practitioners might reject this development (for a review, see Stewart & Chambless, 2010b). However, little, if any, of these writings have come from psychologists in the trenches themselves. Thus, surprisingly little is known about practitioners' actual attitudes and beliefs about psychotherapy research. Much of the current knowledge derives from surveys of practicing psychologists. We identified some common themes from a synthesis of the literature and review these next.

Prioritize Clinical Experience Over the Research Literature

One robust theme emerging from the available research is that clinicians prefer to rely more on clinical experience, and less on the psychotherapy outcome literature, when making treatment decisions. In one of the first empirical investigations of practitioners' attitudes, Morrow-Bradley and Elliott (1986) mailed a survey to members of the American Psychological Association (APA) Division 29 (Division of Psychotherapy) and found that almost half of the therapists reported their experience with clients to be their most important source of information about treatment, whereas only 10% selected psychotherapy research as their preferred source of information. Cohen, Sargent, and Sechrest (1986) identified a similar theme in their interviews with 30 Delaware clinicians. Almost two decades later, in a survey of 591 members of APA Division 42 (Psychologists in Independent Practice) clinicians strongly to moderately agreed that their past clinical experience affects their treatment decisions, but only mildly agreed that current research on treatment outcome has an important impact on typical treatment decisions (Stewart & Chambless, 2007). The theme identified in these three studies is consistent with other research indicating that clinicians consider clinical experience to be a highly influential practice factor (e.g., Riley et al., 2007), whereas research takes less precedence (Cook, Schnurr, Biyanova, & Coyne, 2009b; Nelson, Steele, & Mize, 2006).

Attitudes About Research

It is possible that clinicians do not prioritize research evidence because they object to specific aspects of psychotherapy research. One common objection raised in the literature is the generalizability objection, or the belief that efficacy outcome data do not generalize to clinical practice, and that patients in practice are more troubled, complex, and difficult to treat than patients treated in psychotherapy outcome trials. Nelson et al. (2006) conducted two focus groups with 19 child and adolescent mental health professionals to investigate attitudes toward EBP. Clinicians repeatedly expressed concerns about the applicability of

¹In 2006, the American Psychological Association (APA) Presidential Task Force on Evidence-Based Practice adopted the following definition of evidence-based practice in psychology (EBPP): EBPP entails “the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (Evidence-based practice in psychology, 2006). Although closely based on the EBP definition by Sackett et al., EBPP is slightly different from EBP due to its greater emphasis on clinical expertise. Because the available empirical literature is largely based on EBP rather than EBPP, the focus in this paper is on EBP rather than EBPP.

EBPs to their work in community mental health centers, specifically the transportability of interventions tested in highly controlled conditions to their complex and comorbid client populations. Pagoto et al. (2007) asked members of professional listservs to nominate the top 1–2 barriers and facilitators to using evidence-based practice. Thirty-two percent of the barrier nominations pertained to negative attitudes about ESTs, specifically the belief that ESTs cannot generalize beyond controlled research and are not relevant to everyday practice. Clinicians also expressed concerns that reliance primarily on research evidence and efforts to test psychotherapy similar to a “hard science” (i.e., manualization) degrade the human aspect of therapy, such as empathy, creativity, and the therapeutic alliance.

Larger scale studies suggest that the majority of clinicians may not subscribe to these particular objections. Riley et al. (2007) surveyed practicing psychologists randomly selected from a nationwide mailing list (www.psychlist.com) on their attitudes toward a newly developed website to promote empirically supported treatments (www.therapyadvisor.com). Only a small number of participants indicated that concerns about generalizability to real-world patients (16%), or objections such as treatment equivalence (23%) (e.g., all psychotherapies are equally effective, so there is no need to focus on the efficacy of particular treatments) deterred their adoption of ESTs. Stewart and Chambless (2010b) developed a measure of objections to EST research (including the ones previously mentioned), and surveyed a random sample of independent practice psychologists identified from APA about reasons to pursue or reject training in ESTs. Overall, practitioners held no opinion or mildly to moderately disagreed that each objection (e.g., generalizability concerns, therapy as an art form that cannot be empirically tested, clinical experience as a better guide, treatment equivalence) lessened their interest in learning an EST. It is unclear why clinicians appear more positive about research in large-scale surveys than in open-ended qualitative research with smaller samples. It is possible this difference indicates sampling or response biases, or perhaps results from differences in methodology.

Logistical Barriers

The results from survey research indicate that clinicians do not prioritize psychotherapy research in their decision making, yet they may not be as negative about research as they are often depicted to be. Possibly there is a more parsimonious explanation in the form of logistical barriers—time, money, and training. Cook, Biyanova, and Coyne (2009a) employed an open-ended questionnaire and qualitative analysis to survey 1,630 psychotherapists from a wide range of disciplines on the perceived barriers to adoption of new treatments. The most frequently endorsed theme (68% of cited barriers) concerned training-related issues, such as insufficient time, the high cost of training, and the lack of accessible or local training opportunities. In contrast, 14% of the cited obstacles were related to clinicians' attitudes, such as concerns about a treatment's efficacy, and only 5% of the obstacles concerned clients' characteristics, such as the belief that treatments are not applicable for a particular client population. However, it is important to note that Cook et al. queried about “new” treatments, rather than empirically supported or evidence-based treatments specifically. Nonetheless, Stewart and Chambless (2010b) found that logistical challenges were as important as ideological challenges in influencing practitioners' willingness to obtain training in ESTs. Riley and colleagues (2007) found that participants strongly endorsed the concept that limited time and resources were barriers to evidence-based practices (52% rating 7–10 agreement on a 1–10 scale). Similarly, 19% of the EBP barrier nominations in Pagoto et al.'s (2007) study concerned logistical considerations, such as the resources (e.g., manuals, time, cost, and reimbursement) that are necessary to practice EBP. Twenty-three percent of the barrier nominations were relevant to training, specifically the challenges of keeping up-to-date on training, and training gaps at both graduate and

postgraduate levels. Participants in Nelson et al.'s (2006) focus groups also noted practical barriers: Clinicians reported that EBPs require substantial training for competence, and they do not have the free time necessary to learn new approaches and become proficient in their delivery.

Facilitators

Clinicians have made suggestions as to how best to communicate research findings and how to improve their use of research in practice. Beutler, Williams, Wakefield, and Entwistle (1995) sent surveys to practitioners identified from the National Register of Health Service Providers in Psychology and found that almost half of the clinicians marked clinical newsletters and national conferences as preferred sources to learn about research findings; only 19% selected research articles as a preferred avenue of communication. Cohen et al. (1986) similarly concluded that clinicians are more likely to read how-to books with detailed discussions of the tested treatment than traditional journal articles emphasizing methodology and statistics. Noting their limited time available to keep abreast of research, practitioners in Nelson et al.'s (2006) focus groups suggested that summaries of the outcome literature would be most helpful to them (on the Internet and in practitioner-oriented books), particularly explicit recommendations on translating findings into clinical settings. Similarly, 16% of the EBP facilitators mentioned by Pagoto et al. (2007) concerned how research is presented: Clinicians reported they might be more likely to use ESTs if research was presented in a readable, user-friendly format and if research addressed how to apply ESTs to diverse populations and settings. Interestingly, the most frequently cited facilitator to EBP (24%) concerned policy changes (e.g., professional organizations and third-party payment) that support EBP and increasing the availability of training opportunities through graduate programs, continuing education workshops, and postgraduate institutes.

Purpose of Study

The aforementioned studies provide some information about practicing psychologists' attitudes. It is evident, however, that there is much more to learn. For example, little is known about how clinicians make decisions about how to work with particular clients and factors that influence their efforts to expand their knowledge and clinical skills. Dissemination efforts necessitate that those who wish to disseminate must understand the target adopting group before any successful dissemination can be achieved. With the three notable exceptions of the studies conducted by Nelson et al. (2006), Pagoto et al. (2007), and Cook et al. (2009a), most of our information about clinicians' attitudes derives from survey-based, closed-ended approaches. Although undoubtedly useful, quantitative approaches may limit us from gathering rich and detailed information from practitioners that may inform dissemination strategies. The purpose of the current study was to conduct individual interviews with members of our target population to obtain the clinician's perspective on psychotherapy research, to learn more about how clinicians make treatment decisions in real clinical encounters, and to ascertain their views on EST research and training.

Method

Participants and Procedure

Practicing psychologists from the Philadelphia Society of Clinical Psychologists were invited for semistructured interviews. To achieve a target sample size of 25, the authors mailed 110 recruitment letters to a random selection of psychologists from the Philadelphia Society of Clinical Psychologists. No compensation was offered for participation; however, the recruitment letter noted that participants would be entered into a lottery to win \$250 for a charity of their choice. Eleven letters were returned due to faulty mailing addresses, and

eight practitioners contacted the authors to inform them that they were either too busy to complete the study, or had retired. Twenty-eight practitioners contacted the interviewer (RES) and agreed to participate for a response rate of 31%, and 25 interviews were conducted as planned. The remaining three participants were thanked for their interest and informed that the study had closed to recruitment. Procedures for the study were approved by the University of Pennsylvania Institutional Review Board.

All practitioners held a doctoral degree. Ten participants held a Ph.D. degree in clinical psychology, 10 had earned a Ph.D. in counseling psychology, and five participants held a Psy.D. Participants had a mean of 20.5 ($SD = 8.30$) years in practice and saw an average of 24.8 ($SD = 11.06$) patients a week. Fifteen participants were female, and 10 were male. Participants ranged from 37–67 ($M = 52.3$, $SD = 7.31$) years of age. Almost all of the clinicians mentioned that they agreed to participate to help a graduate student with her dissertation. Only two mentioned the charity lottery as a reason to participate.

The first author, a female doctoral student in clinical psychology, traveled to each participant's office to conduct the interviews. Working from an outline, the interviewer asked each prepared open-ended question and allowed the participants to speak freely on the topic at hand. After gaining general information about each participant's degree, practice, and theoretical orientation, the interviewer asked the clinician to consider the last completed case he or she treated for 10 or more sessions before termination. This was to ensure that each participant had a concrete case in mind and that he or she had seen this patient enough times to speak knowledgeably about decisions and considerations during the treatment. The interviewer asked a series of questions about the characteristics of the patient, how and whether a diagnosis was made, as well as about treatment decisions the clinician made throughout the treatment. After discussion about the case, the interviewer inquired as to the clinicians' views on treatment outcome research, ESTs, and continuing education. The interviewer then asked clinicians what information about their practice is important for researchers to know and what type of research would be interesting to them. Interviews were audiotaped and transcribed by the interviewer and lasted from 45–60 minutes. The interview outline is available online at the link at the beginning of this article.

Qualitative Analysis

Interview data were analyzed consistent with a grounded theory framework, originated by Glaser and Strauss (2008) and expanded by Strauss and Corbin (1997). Although several variations of grounded theory have been developed (see Fassinger, 2005, for a review), all endeavor to generate theory derived from data and illustrated by characteristic examples. This approach was adopted to provide the researchers with a well-established and organized coding system for content analysis that proceeded through several stages of data analysis.

Coders—Coder 1, the first author (RES), was a fifth-year clinical psychology doctoral-level student at the University of Pennsylvania at the time of coding. Coder 2 (SWS) received her Ph.D. in clinical psychology from the University of Pennsylvania in 2005. She completed a postdoctoral fellowship in the Department of Psychiatry at the University of Pennsylvania, and is currently an Assistant Professor at Boston University Department of Psychiatry and a Staff Psychologist at the VA Boston Health care System and the National Center for PTSD.

Both coders study dissemination of psychotherapy research to practitioners and value the application of research findings to practice.

Data analysis—First, the two coders read through all of the transcripts and independently identified distinct concepts emerging from them. One coder identified 30 concepts; the other

identified 39. The lists were combined and resulted in a joint list of 36 concepts. The coders then coded seven transcripts separately and met to adjudicate differences, develop coding rules, consolidate redundant concepts, and create additional codes to reflect new concepts not previously identified. During this process, two more codes were added to the list and four existing codes were condensed to two. Data analysis was presumed complete when the researchers reached conceptual redundancy, or no new concepts or information emerged from the data (Strauss & Corbin, 1997). This saturation point was reached after 20 interviews. A coding manual was developed with a final working set of 32 concepts and used to code the 25 transcripts. A complete list of concepts and examples is presented in Table 1.

Once the data were analyzed, to ensure the trustworthiness of the findings, the researchers shared their findings with an auditor from our target population, who was a practicing psychologist with over 30 years of clinical experience. This auditor had not previously participated in the study. The purpose of utilizing an external auditor who had volunteered to participate in our research was to evaluate whether the findings, interpretations, and conclusions are supported by the data, and to identify and subsequently decrease any bias on behalf of the coders. The auditor read through all of the source data and corroborated all concepts produced by the research team. The auditor did not identify any new concepts not previously identified in the data, and no changes were made to the coding manual.

After completing coding, the coders met and decided upon the important themes emerging from the concepts and the data. These themes were presented to the auditor, who agreed that these were the most important themes to be highlighted. In addition, the auditor suggested a number of themes originating from her own experience in practice. These supplementary themes did not concern the use of research evidence in practice and were, therefore, not pertinent to the aims of the current study. Conversations with the auditor enhanced the interpretation of the data as well as the articulation of the findings in the discussion section of this article. As a result of this external audit, the authors were able to be more confident that their biases had not influenced the interpretation of the data. These themes will now be identified and described in the results section.

Results

The Old Eclectic

Most clinicians described themselves as eclectic or integrative in orientation or mentioned that they draw from several modalities in their practice. For example, one clinician explained: “I subscribe to the dirty word *eclectic*. I feel pretty grounded in psychoanalytic orientation and employ [it] when appropriate in therapy. I look at things from a combination of psychodynamic understanding, cognitive– behavioral understanding and family systems as well— combination of those three that I’ll apply and mix and match.” Almost all of the clinicians noted that they use CBT strategies, including those participants who described themselves as primarily psychodynamic in orientation. Additionally, a significant minority of clinicians noted that they tended to conceptualize cases within a dynamic framework, although in day-to-day work they employ a variety of strategies. For example, one clinician distinguished her conceptualization and intervention strategies: “When I am conceptualizing, I’m very dynamic in how I’m thinking, looking at patterns and unconscious wishes, family patterns, how to identify connections to the choices we make. With clients in actual interventions, I’m a cross between a little cognitive, a little interpersonal, and a lot narrative.” Alternatively, clinicians who designated themselves as CBT in orientation typically commented that their work is not exclusively CBT: “I chose a CBT approach with her [the case], but I think there were components of Rogerian, and interpersonal, and insight-oriented that certainly came into the work I did, and I’m certainly familiar with all of

that work.” In large-scale surveys, clinicians are requested to select one particular theoretical orientation to which they subscribe. When queried in an open-ended format, they mentioned how they pick and choose strategies and orientations as they deem fit for a particular patient. To practicing clinicians, it may appear too narrow to report adhering to one theoretical modality: “I do mostly cognitive– behavioral interventions, but I'm certainly not a CBT guy.”

Empirical Data Are Good (Especially When There Is a Need) but Need To Fit in My Framework

Many of the clinicians noted positive aspects of research, specifically that it is important for them to know what works. As one clinician explained, “There's part of me that thinks that it makes sense, you would want treatment to have some empirical basis, want people to be helped, some measurement about how and that they are helped, more than an intuitive sense that you are helping people. That's a positive in that way.” Although positive about the general idea of ESTs, clinicians indicated that it would be most helpful to them to learn whether and how they could integrate them into their practice: “I'd have to see what it was and if it had real bearing on my work. I'm not closed to it, it's important to know what works, but what I'd think would be `let me learn this technique, let me see how it works, and I will do with it what I need to in order to apply it to my own practice.” Overall, clinicians do not object to the general idea of empirical data. ESTs are acceptable, but only if not taken literally (e.g., rigidly following treatment manuals) and only if they can incorporate specific strategies and components of ESTs into their standard eclectic practice. Several clinicians also noted that they seek out new information when they are “stuck” or when they are presented with diagnoses with which they have minimal experience. For some, they sought out the research literature: “Actually this is a case where I went to the research and did some reading on eating disorders, particularly on binge-eating disorder, and the consequence was that I was more cognitive–behavioral, more concrete, and more directive than I might be in other circumstances.”

Objections to Research

Research is too controlled—Despite conveying some positive attitudes about empirical data generally, almost all participants reported misgivings about research. One commonly expressed theme is that research is too controlled to generalize to their patients. Clinicians often commented that their patients have many comorbid conditions, particularly characterological qualities, that are not addressed in randomized controlled trials and that their patients do not fall in “nice and neat” categories and diagnoses. Clinicians held strong beliefs that all patients with comorbidities (Axis I and II) are screened out of research studies. As one clinician explained: “Of course, I'm not blaming research because that's how research is, you have these carefully preselected pre-screened uncomplicated patients— research rarely reflects reality of who walks through my door. Even if research is relevant in theory, it's enough steps removed from my practice that I have a hard time feeling it provides a compelling case for treating people in a certain way.” Clinicians also held concerns about manualized treatment protocols and often noted that they were too narrow and dogmatic to utilize in clinical practice: “My treatments are more complex than this.”

Research misses the human component of therapy—Clinicians maintained that the very nature of research neglects the human and interpersonal component of therapy. Many noted that it is not possible to quantify the interpersonal sphere of therapy: “It's impossible to test for all of the nuances that happen in a human relationship.” Clinicians' comments also revealed beliefs that manualized treatment is inimical to maintaining a human connection with a patient. As one clinician declared: “I want to have the most informed therapy I can, but for me there is a bell curve where I lose the human connection

with my client if I'm too much in the numbers, in the manuals, and what's validated, or the protocol. So I take it up to a point, and then I need to step back.” Clinicians noted repeatedly that therapy is inherently a subjective phenomenon in an interpersonal setting that cannot be fully understood by research. For example, “ESTs can provide outlines and basic rules. After that it's a person that has to apply that in an interpersonal setting.”

Skepticism about research and how ESTs will be used—Clinicians mentioned a variety of other factors that dampened their enthusiasm about research. Several clinicians were skeptical about the validity of the measures utilized in psychotherapy outcome trials. One clinician illustrated: “I don't know if just because a person scored a standard deviation on x, y, and z measures that that is indicative of a better approach. I guess I'm skeptical.” Similarly, some clinicians maintained that any hypothesis can be validated through research: “You can show anything in research if you want to show it,” and also that certain modalities of treatment lend themselves better to measurement and validation. In addition to skepticism about research results, many clinicians were concerned over how ESTs could be used as “political tools” to dictate practice: “My fear is that it will be used in some mean, nasty way by insurance companies.” Although many clinicians explicitly mentioned that insurance companies should not dictate treatment choice, other participants used general pronouns, and it was not always clear to whom or what they might be referring: “It would be hard for someone to tell me how to practice what they would approve or not approve. I think information based on good research is important, but I think anyone who is not a psychologist should not be making these decisions.” Other clinicians warily asked: “Is everything we do going to have to be measured? Am I doing something wrong by not engaging in certain forms of treatment?” Although clinicians may believe ESTs are a reasonable idea in theory, they had many concerns and fears about how a list of ESTs might be used to hold them accountable or to dictate their clinical practice.

Sources of Learning

Clinical experience—Almost all of the clinicians mentioned clinical experience as an invaluable resource for clinical practice. Many noted that clinical experience was their greatest learning tool. One clinician stated: “I have to tell you that I've learned a lot from all of my work, from being in the trenches and learning, on the front-line doing clinical work every day. And I do what works, I've learned what works—I don't do what doesn't work anymore.” Many clinicians maintained great confidence in their ability to assess what works with their patients. Many commented: “What I do works; people tell me it works.” Moreover, they give more weight to their personal experiences than to research evidence when making decisions about an intervention: “I think I should try to be aware of it [research], but what is always going to be most valuable to me is my subjective experience. And I know when I say that and I know what I'm saying, that's a really bad measure, but I think that's still what I'd go with.” Whereas clinicians may note positive aspects of research evidence, clinical experience and judgment take precedence in patient care: “I still have my approach whether I've read the material or not on its validity. I don't care whether it's been validated or not. I know it's working for this person, and they are feeling better.”

Continuing education—Most of the clinicians reported that continuing education (CE) was valuable. However, although the idea of CE in theory is helpful, most clinicians (including those with less years of experience) noted that CE was far too remedial to be very helpful: “For a person who has a lot of experience, I have to pick and choose very wisely because many of the things would be Mickey Mouse for me—a waste of my time.” Overall, they repeatedly described CE offerings as “unsophisticated, below my level, repetitive, disappointing, and remedial” and noted that they often do not get as much out of CE as they would like. Several clinicians suggested a revamping of CE with prerequisites and beginner,

intermediate, and advanced levels. Most clinicians commented that they have learned to carefully select CEs based on the presenter or organization providing the CE: “I've learned over the years which organizations or people are not helpful and which are more helpful.”

Journals, practitioner books, and peers—Most clinicians denied reading journal articles regularly, often as a result of a personal preference: “I'm not a big journal person.” Clinicians commented that journal articles do not “speak” to them, and several clinicians complained that the format of journal articles is not useful. One clinician noted: “Researchers write for other researchers. I don't need to know all the statistics, the chi-whatever, and what it means. I don't need to read all the details. I care about is there a significant difference, and that's about it.” Several clinicians expressed their wishes that research evidence be better presented for their needs: “I want someone to put it together in a more applicable format” or “Give me a paragraph `what's the bottom-line'—I don't care what you had to do to get to this.” Many clinicians identified practitioner-oriented books as a more directly useful source for learning. One clinician stated: “I'm interested less in journal articles, more texts, here are major tenets of this approach, and here's how it applies to 10 cases. I guess I'm more interested in theory, or a compilation of research into a text, which provides a more helpful complete picture than journal articles.” Almost all of the clinicians mentioned peer networks as a tool for learning. Most engage in peer supervision and consultation through formal and informal peer networks when dealing with a difficult case. Several clinicians noted that they learn about new treatments from colleagues: “I'm like so many other clinicians where we talk to each other, and someone reports a technique and says `try this'—it doesn't depend on whether there's a lot of data on it or not, but if it makes sense to me, and someone I respect recommends it, I'll try it.”

Time and Money Concerns

Time and financial constraints concerned nearly all of the clinicians. Most clinicians mentioned practical factors when picking CE offerings: “I pick also based on location, how far away it is, is it convenient, is it a day I can go actually—I try not to go on days I can see patients because it's a pain to reschedule everybody. And the cost is a factor, I won't go if it's too expensive.” Clinicians also commented that practical considerations diminish their interest in other trainings. As one noted: “If you are on the front lines working a lot of hours, you don't have a lot of time—you don't think, `oh, I think I'll go to a seminar today.' If we don't work, we don't get paid. Especially if the trainings are expensive, and then you lose a day of patients.” Several clinicians mentioned that managed care ceilings have affected reimbursement rates, and in light of diminished incomes, “I'd rather spend my money other ways.” Clinicians frequently cited time as a primary impediment to journal reading and suggest that journal articles are time consuming to read, and the reward in information is rarely worth the effort. Clinicians note that if they have available time, they are more likely to consult practitioner-oriented books. As one clinician commented: “There is always a feeling, `Oh, I should read the *Monitor* and give it its due', but there is the other side of me that if I have 40 minutes to read right now, I want to get something—I'll pick up Nancy McWilliams or another book, and I'll throw the *Monitor* in the recycle bin.”

EST Workshops

Most clinicians expressed at least mild interest in gaining EST training. However, two themes emerged. For many clinicians, EST designation alone was not the determining factor in getting training. As one clinician explained: “My first attention is on `oh, there is something else I can do? Neat. Well, and it's validated—that's cool too.” Another explained: “I would not go there [an EST training] because it was advertised as an EST but because someone I know was a good presenter.” In fact, for the few who said they were not interested, EST designation was seen as a factor that would make them *less* interested: “If

I'm going to be honest, I think my first response would be to be turned off, actually, which is kind of limiting, but I think that's my first response." Additionally, some who expressed interest qualified it by saying that they would be interested if practical barriers such as time or financial concerns could be removed.

Discussion

Consistent with previous research (e.g., Nelson et al., 2006; Pagoto et al., 2007), practicing psychologists express misgivings about the research paradigm, namely that results from psychotherapy research trials are conducted under artificial conditions, are not generalizable, and do not reflect the realities of clinical practice or patients seen therein. Beyond this concern and similar to the findings of Riley et al. (2007) and Stewart and Chambless (2010b), no other objection to ESTs was raised reliably. For example, few clinicians argued that the relationship was the only active ingredient in psychotherapy or subscribed to beliefs about equivalence of forms of psychotherapy. Many of clinicians' generalizability concerns about the applicability of research trials to clinical practice are already being considered in the literature. However, clinicians appear unaware that their claims are not consistent with research findings on these questions, such as research demonstrating comorbidity in RCTs (e.g., Clark et al., 2006; DeRubeis et al., 2005; Leichsenring et al., 2009; Stirman, DeRubeis, Crits-Christoph, & Brody, 2003; Stirman, DeRubeis, Crits-Christoph, & Rothman, 2005) and the effectiveness of ESTs in less controlled clinical settings (e.g., Stewart & Chambless, 2009). More research, however, is needed on how to apprise clinicians of these research efforts in a compelling manner. Given the emphasis on clinical experience as a primary decision-making tool, the presentation of case material that resonates with clinicians might be more likely to inspire clinicians to adopt new treatments or strategies. For example, Stewart and Chambless (2010a) found that clinicians were more positive about ESTs if outcome results were presented with anecdotal/clinical experience data in the form of a case study.

The results of this study also indicate that clinicians hold some positive attitudes toward research products that had not been captured explicitly by previous survey research. Clinicians are not wholly opposed to research. Indeed, most expressed positive opinions about research endeavors in general. Most importantly, clinicians are very interested in learning and knowing about what works in therapy. Consistent with prior research on personal experience (e.g., Cohen et al., 1986; Cook et al., 2009b), the results from this study also suggest that practitioners value peer networks (of their choosing) for consultation and for gaining information about new treatments and may use these networks to get ideas about new approaches. Research on social networks and academic detailing approaches, which emphasize consultation with credible peers (Tan, 2002), may shed light on the extent to which these methods can promote increased use of ESTs in practice.

It is not news that clinicians prioritize and trust clinical experience. Many clinicians in this study asserted that they know when their patients are improving, and empirical verification is unnecessary. Given that available data suggest clinicians are not skilled at predicting which treatments will lead to success or failure for their clients (e.g., Kadden, Cooney, Getter, & Litt, 1989) and that on the whole practitioners are unaware when their clients are failing to improve in treatment (e.g., Hannan et al., 2005), clinicians' high regard for clinical judgment forms a considerable barrier to the adoption of evidence based treatments. It is unlikely that educating clinicians about the literature on the superiority of data-based predictions over clinical judgment (e.g., Dawes, Faust, & Meehl, 1989) would persuade clinicians to weigh research findings more heavily in their decision making. For example, several clinicians in this sample suggested they knew they "shouldn't" rely only on clinical judgment, but still acknowledged it as their most valuable information source. Perhaps

clinicians could be encouraged to collect outcome data on their own clients, so that they could see firsthand where their approach is succeeding or failing to produce change (Lambert, Hansen, & Finch, 2001). Moreover, observations of their own results might interest clinicians in learning ways to increase their effectiveness—a perceived need for a new treatment can be a powerful motivator for treatment adoption (Cohen et al., 1986). It is sobering that only one clinician (4%) in this sample monitored clients' progress via quantitative measures and even then only for severely suicidal patients. More research is needed on how practitioners could be encouraged to routinely collect and consider outcome data and on what kind of data would provide the most meaningful impact (Stirman et al., 2010).

It is highly unlikely that research journals can become an avenue by which to disseminate research findings to clinicians. Consistent with survey-based research from almost two decades ago (Cohen et al., 1986; Morrow-Bradley & Elliott, 1986), the present results indicate that clinicians do not read journals, partially due to time, accessibility, and financial constraints, but mainly because of the journals themselves. Journal articles are dense, perhaps unreadable to those not immersed in scientific language and statistics, and written for other researchers. They are rarely interesting or informative to the average clinician. If dissemination proponents are serious about reaching their target population, they need to communicate their findings in an accessible and palatable way to clinicians. The present results, along with those from previous research (e.g., Beutler et al., 1995; Cohen et al., 1986; Cook et al., 2009b; Nelson et al., 2006), suggest that clinicians may be more likely to turn to practitioner-oriented books and continuing education for new information, particularly if they perceive a clinical need. More research is needed in the meantime on when clinicians perceive this need, and how they might be encouraged to seek out treatment guidance.

A number of publishers (e.g., Oxford University Press and Guilford Press) print book series that are intended to introduce clinicians to evidence-based therapies. It is unclear from this study whether clinicians consult these evidence-based practitioner-oriented books and/or if they find them to be useful. This would be an important question for further research. Where CE offerings are concerned, Stewart and Chambless (2010a) found that evidence-based CE offerings are not readily available. It might be important to know if clinicians would be interested in gaining CE credit for reading evidence-based practitioner books. In addition, only a few clinicians mentioned gaining CE credits online, and those who mentioned this resource also noted these trainings were particularly remedial and thus, unattractive. More research is needed on whether evidence-based Internet trainings are available, and whether such trainings would be attractive to clinicians. Nonetheless, the mere provision of clinician-accessible workshops, home-study, and Internet trainings about ESTs is not sufficient. It is also critical that such offerings are palatable to clinicians.

Herein lies the problem. The present data suggest that clinicians are not against trying or using ESTs in their practice. In fact, almost all of them say that they use CBT techniques regularly for depression and anxiety, regardless of their stated theoretical orientation. However, when they are made to feel that they must use these interventions exclusively, their resistance to adopting them increases. Consistent with other research, these results suggest that many clinicians have misgivings about the application of research results and protocols to their complex patients without modification or integration with other practices. Moreover, much of the concern that was expressed toward ESTs appears to be aimed at the sense of rigidity that is linked to ESTs due to the manualized presentation of the treatments, a perceived dogmatic insistence on adherence to one theoretical orientation, and the concern that research findings on EBPs will lead to nonpsychologists (e.g., insurance companies and policymakers) dictating the nature of practice.

Perhaps the movement to disseminate ESTs would meet with less resistance if greater efforts were made to meet clinicians where they are (Ford, Ford, & D'Amelio, 2008). This might mean that EST proponents would need to shift away from an emphasis on wholesale adherence when introducing these treatments to practicing clinicians. The present findings suggest that books and trainings could be made more palatable by framing ESTs as new techniques that clinicians could use for complex problems with real patients, rather than step-by-step protocols for treating a pure Axis I disorder by which they must abide. Consistent with prior research (Cook et al., 2009b), clinicians in this sample report that they are open to using new techniques within their current framework. It might also be helpful to translate other theoretical models into the language of ESTs and emphasize similarities before encouraging clinicians to modify what they already practice. That way ESTs could be seen as fitting in their eclectic framework. Language is important to consider as well. The present results suggest that designation of a treatment as empirically supported is not sufficient to attract clinicians to training. Indeed it may turn some clinicians away, due to the now loaded meaning of the EST moniker.

More research is needed on how to frame ESTs in clinician-friendly language so as to make them more attractive. For example, prior research suggests that therapists' attitudes toward evidence-based practice may be more positive when the use and mention of manuals are de-emphasized (Borntreger, Chorpita, Higa-McMillan, & Weisz, 2009). Many clinicians in the present sample asserted that manualized treatment degrades the human connection with the patient. Manuals are a necessary component of EST research (Chambless et al., 1998), and it is a misconception that psychotherapists who use ESTs must follow treatment manuals in a robotic fashion without employing their creativity, skills and clinical experience. Flexibility is inherently necessary so that the therapist can respond to the patient and maintain a good therapeutic alliance (Kendall, Chu, Gifford, Hayes, & Nauta, 1998). Moreover, the scant empirical research available on the topic indicates that use of a manual does not in fact lead to lower alliance ratings than treatment as usual (Langer, McLeod, & Weisz, 2011). Such information should be conveyed to clinicians whenever possible. Future research efforts could investigate how to correct misconceptions about manualized psychotherapies.

Although marketing ESTs in this fashion may be antithetical to how some researchers might want ESTs to be practiced and taught, from a pure foot-in-the-door approach it may be easier to foster openness to ESTs by presenting them as new techniques for the clinical toolbox rather than insisting that practitioners abandon what they are currently doing and adopt something entirely new. In the absence of clear findings that a high level of adherence is necessary for successful treatment outcomes within a particular EST (e.g., Webb, DeRubeis, & Barber, 2010), a more effective strategy may be to encourage clinicians to try some empirically supported techniques for specific issues that they face in their practices. If their clinical experience indicates that the techniques are working, they may become more open to integrating more of them into their practice. In other words, it may be better overall for clinicians to be using some empirically supported techniques than none at all. Future research is necessary to examine this empirical question. In the meantime, it is incumbent on researchers to identify what techniques of a treatment package are the critical elements for practitioners (and trainings) to include (e.g., Dimidjian et al., 2006; Jacobson et al., 1996; Resick et al., 2008).

Lastly, consistent with prior research (e.g., Cook et al., 2009a; Riley et al., 2007; Stewart & Chambless, 2010b), the present results indicate that practical barriers can no longer be ignored. It would prove difficult to change the financial realities of self-employment in an independent practice, but it may be easier to develop policies, avenues, and strategies (e.g., web-based training) to make it less burdensome for clinicians to gain new training and support in employing empirically supported interventions in their practice.

A limitation of this study involves the characteristics of the sample. This sample represented a regionally confined subset of psychologists in independent practice who responded to a recruitment letter about the science-practice gap. It is possible that clinicians who agreed to participate are not representative of the larger population of practicing psychologists and that a more diverse sample would show different outcomes. Moreover, psychologists in independent practice are only a subset of psychotherapy treatment providers, and it is possible that other treatment providers (particularly those in the public sector) may encounter different types of barriers to ESTs or hold differing views on research products.

Through in-depth interviews and qualitative analysis, the current study provides much needed information about practitioners, their clinical practice, and their attitudes toward research products. A primary goal of conducting this qualitative study was to determine whether practitioners' views as expressed in a qualitative study are consistent with survey research findings, and we find that they largely are. However, clinicians' attitudes toward research are complex, and this qualitative research illuminated nuances of this complicated issue that are critical to consider for dissemination and implementation efforts. How can this information help to close the science-practice gap in clinical psychology? As with any resolution of two historically adversarial groups, both parties must play a role in reconciliation, and respect and compromise will be the tools through which they can find common ground. The information gleaned from the interviews provides EST proponents with detailed information about everyday clinical practice of front-line clinicians and can help to focus research efforts on how to make research products more acceptable, attractive, and interesting to clinicians.

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Table 1

List of Coding Concepts

Category	Coded theme	Illustrative responses
Participation	I participated to help a student	"I would help anybody with their dissertation if it would only take an hour."
	I participated because I want a voice	"There is a bit of narcissism – oh, my opinion is important and would be valuable."
Orientation/Strategies	Eclectic	"Eclectic sounds so lame and cliché but that is how I would describe myself."
	Integrative	"I describe my orientation as integrative."
	CBT	"I do a lot of cognitive behavioral kinds of interventions."
	Psychodynamic	"I use a lot of psychodynamic concepts."
	Interpersonal	"I'm intensely interpersonal, relational."
	Family Systems	"I look at things from a family systems understanding."
	Developmental	"I have had a lot of developmental training."
	Client-Centered	"I start out fairly client centered."
	The relationship is the active ingredient	"General rule of thumb is that the relationship with the client is what makes it."
Attitudes about Research	Positive statement about research	"I like to make sure that my treatments are supported by good data."
	I use ESTs if they fit in my framework	"If you can show me stuff that works and I can fit it in comfortably, I'm open to it."
	I turn to research (or seek out other information) when there is a need	"I don't routinely research the outcome literature when addressing a particular problem. But if someone has a problem I'm not familiar with I would do that."
	I follow "Best Practice" guidelines	"I'll look from time to time to those Best Practice Publications to advise me."
	Research is too controlled	"They [researchers] screen the clients so thoroughly that they don't look anything like mine."
	Research misses important human component of therapy	"It's so hard to test for, all of the nuances that happen in a human relationship."
	I am skeptical/nervous about research evidence/ ESTs	"You can show anything in research if you want to show it."
EST Training	I feel guilty I don't read research	"I always feel guilty that I don't read enough and wonder if I'm keeping up with current things enough."
	I am interested (not interested) in EST Training	"Yes, yes, I would be interested in an EST workshop."
Practical Concerns	EST designation is (is not) important	"Whether or not it's an EST would not interest me."
	Time	"If we don't work, we don't get paid, so it's hard to give that up for one day of training."
	Money	"Training is costly!"
Continuing Education	Insurance as a factor	"I get reimbursed less from the same insurance company than I get now, 27 years later."
	Positive statement about CE	"I would say I find it [CE] helpful."
	CE is remedial	"What often happens to me is that they [CE offerings] are at too elementary a level."
	I pick CE based on the presenter	"Part of what I look at is credentials of presenter."
Sources of Learning	I pick CE based on practical factors	"Convenience and cost are certainly factors in my choice, not sole factors, but important."
	Clinical experience	"I would say my clinical experience has been the biggest teacher."

Category	Coded theme	Illustrative responses
Desired Research Topics	Peer networks	"I learn from consultations with other clinicians in this practice."
	Journals	"I don't find the journals present it in a format that is useful enough."
	Practitioner books	"I read professional books almost exclusively."
	Comorbidities	"I'd be interested in research that took into account multiple diagnoses."
	Personality	"I guess research that has comorbid Axis I and Axis II disorders ... would interest me."
	Eclectic orientations	"Studies focus on one orientation – often probably the majority of clinicians are eclectic."