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IS EMPIRICAL RESEARCH COMPATIBLE WITH CLINICAL PRACTICE?

Christopher Clulow, Avi Shmueli, Christopher Vincent and Christopher Evans

ABSTRACT This paper explores the provocative question in the title through the authors' experiences of working within a couple psychotherapy service. In it we hope to chart how it became possible to undertake empirical research in a clinical setting. Underlying the question we found a number of others. For example, when and how does empirical research threaten or enhance couples' therapies? Is empirical research a toxic introject, an idealized object and/or a real cultural, developmental experience for a clinical service? The process of change described in this paper involved conflict and took time to develop. We hope to demonstrate that what was achieved was done without detriment to the quality of the service offered and was not at the expense of those who used it. Our view is that the careful engagement we describe is most likely to have had a beneficial impact on both.

Introduction

Empirical research and clinical practice have long been uncomfortable bedfellows (Fonagy 2000). There can be many reasons for this. Among the

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legitimate concerns of clinicians is the fear that research intrudes upon the therapeutic relationship, changes the nature of experience and impoverishes its meaning by capturing only what is measurable. Among the legitimate concerns of researchers is the suspicion that clinical insights are self-referential, unsubstantiated by reliable evidence and theory-driven.

Attempts to bridge the divide between clinical and research perspectives are beginning to develop. The latest influential comment from the Department of Health defining research recommends that:

> Services must promote innovation and its benefits whilst protecting participants from risk and waste. Innovation embraces a much wider range of activities than those managed formally as research. Research can be identified as the attempt to derive generalizable new knowledge by addressing clearly defined questions with systematic and rigorous methods. (Department of Health 2000, section 1.7, p. 4)

Empirical research, like clinical practice, takes different forms and adopts different methodologies. For the purpose of this paper, it is taken to be research which is based on an experimental or quasi-experimental or other 'rigorous' design for collection of data. Interpretation of those data should influence our understanding of the research area. That interpretation should be generalizable to some extent, even if only to raise a new question for another study.

In psychotherapy, empirical research is often thought to be most applicable to the behavioural therapies, and to offer little to the study of the intersubjective phenomena of primary concern to psychoanalytically orientated therapists. This is a misconception. There is, for example, a strong empirical approach to assessing transference phenomena in therapy sessions (Luborsky & Crits-Cristoph 1998). The challenge for therapists is to specify how what they believe to be true about the human condition can be put to the test. In a political climate that demands an evidence base for practice, it is equally important that evidence should be practice-based (Margison *et al.* 2000).

The Tavistock Marital Studies Institute (TMSI) offers psychoanalytic psychotherapy to couples seeking help for their partnership. An assumption arising from the experience of treating couples, that has been accrued by staff over many years, is that persisting conflict between partners stems from the meanings they, separately and together, ascribe to the events, behaviours and communications that impact upon them. These meanings will often reflect unconscious phantasies in their relationship against which they have constructed a shared defensive system (see, for example, Clulow, Dearnley & Balfour 1986). The therapeutic process therefore involves uncovering these defences and the purposes they serve, as well as working with the anxieties they are intended to keep at bay and the affects associated with them (Ruszczynski 1993). From this perspective, unconscious assumptions about relationships derived from early family experiences are presumed to

bear more powerfully on the genesis and management of conflict than, say, consciously learned communication skills. But how is this presumption to be put to empirical test?

A team of staff from the TMSI constructed a research proposal whose principal aim was to examine links between the attachment patterns of partners and the tactics they use to manage conflict in their partnership. The focus on attachment patterns was justified by the link established by research (Bretherton 1985) between this classifiable variable and the 'internal working models' described by Bowlby in his attachment trilogy (Bowlby 1969, 1973, 1980), a construct that corresponds closely to the internal world of object relations that psychoanalytically orientated psychotherapists believe have such an influence upon social relating. The team's research protocol proposed using the Adult Attachment Interview (George, Kaplan & Main 1985), the Secure Base Scoring System (Crowell *et al.* 1998) and an unpublished questionnaire of attachment status to provide representational, observational and self-report perspectives on attachment. Conflict management tactics were to be assessed through a self-report measure, the Conflict Tactics Scale (Straus 1979), and an observational measure, the Interaction Dimensions Coding System (Julien, Markman & Lindhal 1989). In addition, data were to be collected about health and marital satisfaction, and therapists were to be asked to make their own assessment of conflict in the couple relationship using a self-styled questionnaire based on the Kleinian construct of paranoid-schizoid and depressive positions, and on their own countertransference experience of conducting the initial consultation.

What would be the operational implications of implementing this proposal? Would it be possible to recruit a research sample from distressed couples who were seeking help? In what ways might the help-seeking process be affected by the impact of the research on couples and therapists? And would there be lessons to be drawn from the experience? This paper is addressed to these questions, drawing on the results, and experience, of conducting a pilot study of the relationship between attachment status and conflict management tactics in couples seeking psychotherapeutic help.

The Feasibility of Researching a Clinical Population

We were in no doubt about the demands we would be making of couples by inviting them to participate in the research. After they contacted the TMSI for help couples would normally receive a consultation appointment. With the research, this appointment offer was accompanied by another letter outlining the research project and inviting both partners to consider participating. While we tried to maintain the boundary between the research and therapy (assuring couples that their access to help would not be affected by how they responded to the research invitation, and offering payment for their involvement in the research while continuing to apply our normal

charging practice for the consultation), we could not be sure that the boundary would be as clear to the couples as it was to us.

If they decided to opt into the research we would be asking half a day of their time in addition to the consultation that they had requested. In the first place, they would meet with a researcher who would explain the purpose of the research and answer any questions they might have. They would then be asked to sign a consent form. Once this preliminary was completed they would be asked to undertake the first research task. This involved them as a couple, without any outside help, trying to discuss and make headway with the problem that had brought them for a consultation. This 15-minute task would be videotaped. The data from this exercise would be analysed by the Secure Base Scoring System and the Interaction Dimensions Coding System. The couple would then be introduced to a therapist and have the consultation that was their primary reason for contacting us; the consultation would also be videotaped. The therapist would complete a questionnaire after the consultation. There would then be a break, with the researcher providing some refreshment and supplying the couple with a battery of questionnaires in booklet form to be completed after the break. Finally, each partner would separately undertake the Adult Attachment Interview, a semi-structured questionnaire designed to elicit their representation of early childhood relationships. All the procedures were to be completed in one visit to ensure that we had a complete data set for every couple participating in the research.

During a 10-month period ending in March 1999 the research team piloted these procedures with all the couples approaching the TMSI for help. Consultation with the staff ensured there was support in principle for the research to go ahead, and detailed work in the Assessment Workshop (which at that time managed the intake boundary of the TMSI's clinical services) on distinguishing between research and therapy procedures, and the letters that made the distinction clear, ensured that couples were properly notified about the research.

In that period 14 couples opted into the research and completed all the research tasks. There was also 100% completion of the therapist questionnaires. However, for the period of the study 146 consultations were offered, some few of which were with one partner only and so would not have been eligible for the research. In sum, we estimated that one in nine of the couples approaching the TMSI participated in the project. We concluded from this that it was feasible to carry out empirical research procedures in a clinical setting, but that there would be problems securing a research sample of sufficient size to test the hypotheses of the main study. As a result, we decided on a two-centre study, and were delighted with the enthusiasm of the London Marriage Guidance Council for collaboration in recruiting the research sample needed once we were successful in securing funding. In view of the sample representing one in nine of couples seeking therapy there

would also be questions about the generalizability of results. However, after allowing for exclusion criteria, many psychopharmacology research studies take a sample that represents considerably less than 10% of patients presenting (Baldessarini, Tohen & Tondo 2000; Haberfellner 2000; Yastrubetskaya, Chiu & O'Connell 1997), so we were not unduly discouraged.

The main purpose of the pilot was fulfilled. Not only could we demonstrate that it was possible to collect a clinical sample but we also had an opportunity to address problems in administering the research procedures. The research problems we encountered ranged from the technical (siting the microphones to ensure good sound quality) to more serious problems about the interviewing protocol used in conducting the Adult Attachment Interview. By resolving these problems the research team felt better prepared to conduct the main study (which has yet to be undertaken). The data analysis and findings from the pilot are reported elsewhere.

The Impact of Research on the Help-seeking Process

One clinical concern of staff was that by disseminating information about the TMSI's involvement in research we would discourage couples from using our services. There was no evidence for this. The number of couples seen for consultations showed little departure from usual patterns. We also discovered that some couples were positively attracted to the service because of the research and its impact on the financial cost of arranging a therapeutic consultation. Those couples who opted into the project were usually genuinely curious about the research, valued how seriously they were being taken and occasionally asked to be kept informed of the outcome. The main frustration for them was the time commitment, which added up to 4–5 hours spent at the TMSI in total.

We wondered whether their gift to us of the research material might have lessened anxiety about seeking help by establishing a reciprocal relationship with the TMSI, rather than a unilateral one in which they felt dependent upon us for help with their difficulties. Would that have any connections with their state of mind as captured by the Adult Attachment Interview? For example, one might speculate that partners rated as insecure and dismissing of attachment would have the most difficulty with committing themselves to therapy. A research relationship, in which others depended on them for data, might be preferable to a therapeutic relationship in which they were dependent on others for help. The design and size of the pilot did not allow us to test this proposition. However, at the level of individual case analysis there were grounds for believing that a research 'ticket' helped some couples over the threshold into therapy (Clulow, Riddell & Shmueli 2001).

We also wondered whether there would be any association between attachment status and each partner's assessment of the consultation (which might also be an indirect assessment of their experience of being research

subjects). Once again we could not test for this statistically. However, we noted that all the subjects rated their consultation on one of the top two points of a five point scale (very helpful or helpful). This means either that they were a very satisfied group of users or a compliant population – which might be relevant to their decision to agree to participating in the research.

Most importantly, we wondered whether the research experience might affect whether couples chose to go on to therapy or ended their contact with us after the one meeting. Eight of the 14 couples went on to take up offers of therapy (57%), and, of the remaining six, four returned for further consultations. In the year in which the pilot sample was collected there were 168 consultations and 44 couples starting therapy. Allowing for the fact that these figures include multiple consultations, and consultations with one partner only, it seems that couples were not put off therapy as a result of their decision to become involved in the research, and that the procedures may have been a helpful preliminary to the therapeutic process. An alternative view would be that the couples opting into the research were a very motivated group and that this accounts for the high take-up of therapy.

The evidence suggests that the initial anxiety that the staff team as a whole had about the effect of the research on applications for and the uptake of therapy were unfounded, and had more to do with the newness and unfamiliarity of the venture for them. The project benefited from not being the first research sample to have been recruited from couples applying for therapy; so concerns were fewer than on the first time around. This allowed the administration of the research to run smoothly, and for couples to be protected from the possibility of the procedures being sabotaged as a consequence of therapist anxiety about or hostility towards the project.

By delineating very clearly between research and therapeutic procedures the consultation process ran in parallel with rather than became confused with the research. However, there were three significant differences. Firstly, the consultation occurred in a research context. It followed a research task that had the potential to be very distressing for couples (trying on their own to make headway with the problem for which they had come for help). This had some positive effects in that couples had time to 'warm up' for the consultation, and the fact that the researcher was on call should either partner find the task too distressing contributed to creating an atmosphere of safety. Other research procedures followed the consultation and so did not intrude upon it. Secondly, the consultation was videotaped. This was a major departure from normal practice, and its part in the dynamic of the consultation process sometimes needed to be made explicit in the work. Finally, therapists completed a questionnaire after the consultation, and it might be thought that this skewed what was attended to in the session. There is always the possibility that prior knowledge of the questions shaped their thinking and interventions; on the other hand, most of the questions were devised by

therapists and related to dimensions of the consultative process that they would, in any case, be attending to.

There is no doubt that the task of carrying out both research and therapeutic processes was helped by the three members of the research team also being couple therapists and taking responsibility for conducting most of the consultations. (The member who conducted the consultation would not be involved in any of the research procedures that the couple undertook.) This allowed the team to become familiar with the process and to become used to working while being videotaped. Their ability to do this was facilitated by the support of the staff as a whole for what they were doing, who could also be relied upon to provide additional staff resources when needed.

Combining Empirical Research and Clinical Practice

The pilot project described in this paper followed a period of many years during which staff had struggled with the question of whether and how the TMSI should engage with empirical research. While there was a wish to extend the knowledge base for couple psychotherapy, there was more confidence that this would be achieved through conceptual research and clinical practice than through applying standardized methods that were unlikely to be able to address the subtleties and intricacies of relationship processes. Struggling with these questions is nothing new within the psychoanalytic community. In 1994 and 1995, delegates attending three conferences marking an anniversary of the *International Journal of Psycho-Analysis* discussed the place of research in psychoanalysis. A central question raised in their proceedings, and in papers published subsequently, concerned whether a psychoanalytic fact can be registered by anyone other than analyst and analysand. One argument put forward was that the experience with which psychoanalysis is concerned is generated within the intersubjective domain of the transference and countertransference and is not, therefore, accessible to third parties nor by methods that do not properly belong to psychoanalytic technique (Caper 1994). This view is challenged by analysts who espouse the objective value of good case reporting which enables something of the essential nature of psychoanalysis to be communicated (Tuckett 1994). The scepticism within TMSI remains, but it is a proper scepticism about claims that might exceed the limitations of any approach to scientific enquiry rather than a turning away from the unfamiliar. So a dialogue has become possible. In accounting for this change in culture there are three factors that have played a key part: a convergence of the fields, leadership and a supporting environment.

Convergence

Following an examination of factors in couple applications for psychotherapy associated with the uptake of therapy (Cohen, Fisher & Clulow

1993) the TMSI's Assessment Workshop began to shape a number of research questions around important technical issues, which included the criteria for offering psychoanalytic psychotherapy to couples, whether it is best to deploy two therapists rather than one, and whether the gender of the treating therapist is an important assessment consideration. These questions implied an interest in outcome. As a first step to collecting data that might help to answer these questions the format for assessing couples at the start and end of therapy was revised and standardized.

The format allowed questions to be asked about whether different therapists would assess the same couple in the same or different ways. For example, an internal report on the process of developing clinical research in the unit recorded in relation to countertransference phenomena that:

> if [countertransference] is understood to be a transaction between the couple (and, of course, each partner) and the therapist(s) which functions as a means of unconscious communication from the couple, then it might be thought that the countertransference is in essence specific to the couple and would be experienced in a *roughly similar way* by any therapist in an encounter with that couple. We were quickly into the dilemmas of establishing *inter-rater reliability* as we tried to find a shared way of describing and evaluating assessments. (Fisher 1997, p. 3)

Two internal measures were subsequently devised to assess couple functioning. The first was a six category definition of interaction between the couple on a linear scale of increasing disturbance in the capacity for both intimacy and differentiation of the experience of each partner as a separate individual (based on Klein's model of paranoid-schizoid and depressive functioning). The second was a 23 item checklist of therapist countertransference in three areas: cognition (being able to think clearly and follow the couple's thinking), affect (experiencing an emotional reaction and being able to reflect on it) and action (behaviour towards the couple and co-therapist, effects on managing boundary issues and so on). Both these measures were included in the therapist questionnaire in the pilot study.

Having worked to devise a research instrument that was faithful to the practice of psychoanalytic psychotherapy with couples and capable of being subjected to tests of inter-rater reliability, staff were eager to discover established research measures that might be used alongside those capturing clinical judgement. The major turning point came with learning about the properties of the Adult Attachment Interview, a validated and reliable measure of individual attachment security that has the capacity to tap into unconscious processes by analysing not what people say about their early family relationships but *how* they say it, thereby accessing their representational worlds. This instrument represented a convergence not only between the concerns of researchers and practitioners but also between attachment and object relations theories. As one review of attachment research put it:

> . . . attachment theory can now more clearly be seen as a theory of interpersonal relationship in the lineage of object relations theory, incorporating much from ethology, but also shedding new light on and reworking from a new and rigorous perspective the issues with which Klein, Fairbairn and Winnicott had also been wrestling. (Bretherton 1991, p. 27)

With the help of research consultancy a team of staff went on to try and develop a measure of attachment security for the couple, piloting it with couples attending the TMSI for therapy (Fisher & Crandell 2001). The psychometric challenge posed by this instrument remains to be addressed, but the work involved in creating it whetted the appetite for empirical research in the unit. Perhaps as important, clinicians were prepared to think about including conventional research measures in studies (despite their limitations from a clinical perspective) if that would provide credibility for proposals that would include innovative measures capable of eliciting the data that were of most interest to therapists.

Leadership

Venturing into new territory is potentially hazardous. There must be sufficient conviction and enthusiasm for the enterprise to be successful, and mobilizing these qualities calls for leadership. Over the years, staff met with different empirical researchers who have been enthusiastic about their work and eager to involve the TMSI in it. However, a turning point for the unit was the emergence of a leader for the research project from within its own ranks. Crucially, this person commanded respect among his colleagues as a clinician who was committed to psychoanalysis and its application to couple psychotherapy. He was able to engender trust among his peers that research would be in the service of psychoanalytic psychotherapy with couples and not the other way round.

While he was most prominent in driving the initiative during a crucial stage of its development, there were other individual members of staff who then and subsequently took responsibility for developing questionnaires, managing research tasks and organizing data in ways that made them accessible and usable. The conditions were created in which the research 'baton' could be handed on and run with.

A Supporting Environment

The Tavistock Marital Studies Institute has as one of its three principal activities the development of practice-based research. From a management perspective it was therefore not difficult to justify the allocation of time and resources to foster the exploration of empirical methods that would develop understanding of the couple relationship and the therapeutic process, and there was enthusiasm for doing so.

Crucially important to the development of both pilot projects was the groundwork achieved as a result of professional consultation received from

the Developmental Psychopathology Research Unit at the Tavistock and Portman Clinics NHS Trust. This, plus the valuable consultative help received from two close colleagues from the Department of Psychology at the University of California, Berkeley, during their sabbatical visit when the second pilot (reported here) was being planned and implemented, meant that we had firm encouragement and good advice.

Financial help from the Tavistock Institute of Medical Psychology enabled the fieldwork to be carried out, and a grant from the Lord Chancellor's Department funded the analysis and dissemination of findings. Such support, in itself, is an agent of change.

Practitioner attitudes have clearly been affected by a political climate that is increasingly asking for an evidence base for professional practice as the precondition for spending public money. While questions asked from this quarter are a proper spur to action, the risk remains that validation by empirical research becomes the only benchmark by which activities are judged as being good and worthwhile. Any activity needs to be judged according to what it sets out to do. Researching the tangled web that binds couples together is a complex task, as is the process of assessing what kinds of help do and don't work for different couples. We need to be sceptical of claims that surpass what research can deliver.

Effecting a Shift in Culture

This paper has explored three questions arising from undertaking empirical research in a clinical setting: Is it possible to recruit a research sample from couples seeking help? Does involvement in research affect the help-seeking process? What factors make for a constructive engagement between clinical research and psychotherapeutic practice? An attempt has been made to address each question, and to identify further questions that have followed from the process of engaging with them.

The TMSI is different today from ten years ago, and part of this change is attributable to its engagement with empirical research. While we were slow to apply available technology, the unit now has a video suite that is being used for the recording of therapy sessions for training purposes as well as for research. Another project is building on work described earlier, using Kleinian constructs to develop a measure of couple functioning. This is being taken forward by adapting for use with couples an empirical measure first developed for individuals by colleagues in the Developmental Psychopathology Research Unit. The TMSI is now better connected than it was with psychotherapy researchers in this country and overseas, and becoming part of such a network is a positive stimulus to the work. Some courses that it runs now have academic accreditation and a research component.

But it is right that alongside the excitement of the new should run some caution and questioning about an alliance that is never going to be without

its problems. Not everything is researchable, nor should it be. The pursuit of empirical research needs to be weighed up alongside the need for other kinds of research. Good clinicians do not necessarily make good researchers, nor do good researchers necessarily make good clinicians. A sense of professional identity and competence is crucial. Our hope in writing this paper is to demonstrate that some shift in culture that allows a dialogue between research and practice is possible, may be exciting and can be fruitful.

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