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# Addressing Challenges and Barriers to Translating Psychotherapy Research Into Clinical Practice: The Development of a Psychotherapy Practice Research Network in Canada

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Despite a large body of research indicating the effectiveness of evidence-based psychotherapies and therapeutic processes, there remains a practice–research divide. Clinicians do not consistently use evidence to inform their treatments, and researchers do not often rely on clinicians' knowledge to inform their research. This divide is partly due to identifiable barriers. Practice research networks in psychotherapy may be 1 means of bridging the practice–research gap. In this article we use theory of planned behaviour (TPB; Ajzen, 1991) to help to understand the barriers experienced by clinicians in using psychotherapy research. We also evaluated the TPB model by an empirical study of 68 clinicians who attended a conference on practice research networks and who completed a TPB questionnaire prior to the conference. Clinician attitudes toward psychotherapy research, the social norms they experience within their practice settings, and their perceived behavioural control over implementing research were each uniquely and significantly related to intention to use psychotherapy research to inform practice. Intentions were correlated with behaviour change in health professionals. We conclude by describing the development of the Psychotherapy Practice–Research Network (PPRNet) as a unique collaborative approach to bringing clinicians and researchers together to diminish barriers by improving attitudes, social norms, and perceived behavioural control among clinicians and researchers. The PPRNet will help to inform clinical practice and generate psychotherapy research that is more meaningful to clinicians and more practically applicable.

*Keywords:* practice research network, practice–research gap, best practices, theory of planned behaviour, knowledge translation

Based on recent statistics, over 1 million Canadians saw a psychologist or psychotherapist in the past year for mental health or addiction problems (Cox, 2014; Vasiliadis, Tempier, Lesage, & Kates, 2009). The rates of psychotherapy use have remained the same or declined slightly over the past decade, concurrent with the dramatic rise in the use of antidepressant medication during the same period (Olfson & Marcus, 2010). Regardless, a large number of Canadians turn to psychotherapy for their mental health needs, to reduce their suffering, and improve their quality of life (Bradley & Drapeau, 2014; Cohen & Peachy, 2014; Votta-Bleeker & Cohen, 2014). There is a large body of research that has consistently demonstrated positive outcomes of psychotherapy for a wide variety of disorders (e.g., Fonagy, Target, Cottrell, Phillips, & Kurtz, 2002; Nathan & Gorman, 2007). Psychotherapy is as effective, and possibly more effective than medications for treating some common mental health problems such as depression (Forand & DeRubeis, 2013). Nevertheless, there remains a significant practice–research divide when it comes to psychotherapy (Boisvert & Faust, 2006; Wilson, Armoutliev, Yakunina, & Werth, 2009). That is, clinicians often do not use existing research to guide their practices (e.g., Fitzpatrick, 2012; Drapeau & Hunsley, 2014), and researchers typically do not rely on clinicians' input when designing psychotherapy research (Beutler, Williams, Wakefield, & Entwistle, 1995). This divide, in part, has motivated the creation of task forces on the dissemination of evidence-based approaches (e.g., APA Presidential Task Force, 2006; Dozois et al., 2014; Norcross & Lambert, 2011). Some task forces have created lists of evidence-based treatments (e.g., Fonagy et al., 2002; Hunsley, Elliott, & Therrien, 2013; Nathan & Gorman, 2007) and reviews of evidence-based practices (EBP; e.g., Norcross & Lambert, 2011). Although these lists document best practices in

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psychotherapy, they do not appear to have had an impact on clinicians' willingness to adopt these interventions (e.g., Tobin, Banker, Weisberg, & Bowers, 2007; von Ranson, Wallace, & Stevenson, 2013).

One way of conceptualising the practice–research divide is to understand it as a gap between knowledge and action, which in turn can be situated within a knowledge-translation framework. Graham and colleagues (Graham et al., 2006) defined knowledge exchange as collaborative problem solving between researchers and clinicians that results in mutual learning. Graham and colleagues (2006) described the knowledge translation process in two stages: (a) knowledge creation and (b) the action cycle. It is the second part of this two-stage process that is lacking in the field of psychotherapy (Beutler et al., 1995; Boisvert & Faust, 2006; Wilson et al., 2009). The action part of the cycle is based on planned-action theories (e.g., theory of planned behaviour; TPB; Ajzen, 1991), which focus on changing health behaviours of individuals, including health professionals (Godin, Belanger-Gravel, Eccles, & Grimshaw, 2008). When applied to the practice–research divide in psychotherapy, the action cycle identifies key steps, including identifying the problem (i.e., the practice–research gap in psychotherapy), assessing barriers to knowledge use (discussed below), implementing interventions to overcome barriers (e.g., developing a practice research network, or PRN, also discussed below), monitoring knowledge use and evaluating outcomes, and sustaining knowledge use.

In this article we focused on the barriers to using psychotherapy research to inform clinical practice. In doing so, we used TPB constructs (Ajzen, 1991) to help to understand the barriers, and evaluated the TPB model in this context by presenting an empirical study of clinicians who attended a conference on practice research networks. TPB factors have been shown to predict intentions (or motivation) to engage in health behaviours (Ajzen, 1991), and intentions are highly correlated with health professionals' behaviours in clinical practice (Armitage & Conner, 2001; Eccles et al., 2006; Godin et al., 2008). For example, Godin and colleagues (2008) conducted a meta-analysis of 72 prospective studies of physicians, nurses, and other health professionals in which intentions were used to predict subsequent behaviours, such as compliance with guidelines for prescribing, hand hygiene, documentation, and acceptance of technologies, among others. Intention was significantly associated with subsequent self-reported behaviours ($R^2 = .44$) and with objectively observed behaviours ($R^2 = .13$) among health professionals (Godin et al., 2008). We argue that by applying the TPB factors to better understand the barriers to translating psychotherapy research into practice, one can reinterpret the nature of these barriers and therefore better articulate an intervention. We concluded the paper by describing the development of the Psychotherapy Practice–Research Network (PPRNet) as a specific intervention to address TPB-based barriers and to reduce the practice–research gap.

## Understanding the Barriers

Unlike the quickly emerging research literature on understanding the implementation of EBP in other areas of health care (e.g., Godin et al., 2008), there is currently little or no literature on theories and methods of changing clinicians' behaviours to use research to inform their delivery of psychotherapy. To explain clinicians' behaviours and treatment choices, some researchers have invoked concepts such as clinician cognitive biases and dissonance, and clinician decision errors based on a faulty understanding of probabilities and base rates (Lilienfeld, Ritschel, Lynn, Cautin, & Latzman, 2013). However, these concepts have not been tested in the context of integrating psychotherapy research into practice, and so we do not know if they represent adequate explanations for the current state of affairs. Although invoking these concepts has some intuitive appeal, it may have unintended negative effects. First, academic researchers who highlight clinicians' purported cognitive biases may unintentionally further alienate clinicians from appreciating the benefits of research for clinical practice. That is, clinicians may experience this characterization of their clinical decision making as patronising. Second, such conceptualisations do not explore researchers' behaviours and attitudes as possible barriers to integrating research and practice. For example, some have suggested that researchers are reluctant to include clinicians on research teams and may devalue clinician input (Beutler et al., 1995). Third, these models of clinician cognitive biases do not necessarily provide a conceptual framework or theory that can inform interventions or processes that will overcome barriers to using psychotherapy research and change clinician behaviours.

Based on the research evidence, one can identify at least three barriers to translating psychotherapy research into clinical practice. First, a concern among clinicians is that although EBPs are based on highly internally valid studies, findings from this research may not generalise to more diverse real-world populations, which clinicians have indicated they treat (Kendall & Chambless, 1998; Westen, Novotny, & Thompson-Brenner, 2004). As a result, some express concern that practitioners pay little heed to research (von Ranson & Robinson, 2006), and clinicians counter that psychotherapy research is not always relevant to real-world practice (Westen et al., 2004). A second barrier to implementing psychotherapy research is a lack of communication between clinicians and researchers, resulting in a translational gap between clinical trials and clinical practice. Community-based clinicians may feel disconnected from research that is designed and implemented in health-sciences and academic centers (Beutler et al., 1995). By the same token, as mentioned earlier, researchers may place a lower premium on information gleaned from clinicians and may not readily use this knowledge to inform their research (Beutler et al., 1995). Despite this, a recent survey has indicated that Canadian psychotherapists are interested in research (Lau, Ogrodniczuk, Joyce, & Sochting, 2010), and others have reported that clinicians' behaviours change when they are made aware of research relevant to their practices (Stewart & Chambless, 2007). A third barrier is related to the professional diversity of psychotherapy practitioners. Unlike many other areas of health care (e.g., dentistry, optometry, medical specialties), psychotherapy is practiced by a broad array of professionals (e.g., psychologists, psychiatrists, counsellors, social workers, among others) in a variety of settings (e.g., private offices, community clinics, rehabilitation centres, hospitals), and for a wide range of client problems (e.g., addiction, anxiety disorders, depression, eating disorders, etc.). Training in psychotherapy practice and in the conduct and use of psychotherapy research also varies greatly. Further, different regulatory colleges require different standards of training, continuing education, and regulatory requirements, and different professional organisations have different criteria for accreditation.

### Reinterpreting the Barriers

The gap between research and practice has been explored in many domains and multiple theories have been used in doing so. The TPB is the most widely used theory in the realm of knowledge translation to predict health professionals' clinical practice behaviours (Godin et al., 2008). The TPB constructs of attitudes, social norms, and perceived behavioural control are believed to influence the intention (or motivation) to behave in particular ways (Ajzen, 1991). Attitudes toward the behaviours reflect an individual's positive or negative evaluation of behaving a particular way. Social norms refer to an individual's perception of social pressure to behave a certain way. If people perceive that their significant others endorse or disapprove of a behaviour, then they are more or less likely to engage in that behaviour. Perceived behavioural control refers to one's own self-efficacy and sense of control over engaging in the behaviour. The TPB model has been used to predict intentions to engage in health behaviours (e.g., condom use, smoking cessation), and exercise behaviours in the general population (Armitage & Conner, 2001). Reviews and meta-analyses have indicated that the model performs well, such that attitudes, subjective norms, and perceived behavioural control predict intentions, which in turn predict engaging in healthy behaviours (Ajzen, 1991). However, TPB constructs tend to be better at predicting self-reported behaviours than observed behaviours (Armitage & Conner, 2001; Godin et al., 2008). In a meta-analysis of studies focused on predicting health professionals' behaviours (i.e., dentists, physicians, nurses, pharmacists, psychologists, social workers, and other mental health professionals), TBP constructs (attitudes, social norms, perceived behavioural control) explained 59% of the variance in intentions and 35% of the variance associated with their behaviours (Godin et al., 2008). Intentions and behaviours were significantly related in a separate meta-analysis ($R^2 = .22$, $p < .001$; Armitage & Conner, 2001), and in a systematic review ($R^2 = .15$ to .40; Eccles et al., 2006).

The first TPB factor is the clinician's Attitude or appraisal of the behaviour. For example, a practitioner may value or devalue the use of manuals or evidence-based psychotherapeutic stances. The second factor, Subjective Norm, is defined as the social or peer expectations that may determine the behaviour. For example, a clinician's willingness to adopt research recommendations may be influenced by their professional or peer groups' views of research. The third factor, Perceived Behavioural Control, is defined as the available resources (including the availability of knowledge), opportunities to engage in the behaviours, and self-efficacy. Some clinicians, for example, may not have access to training or knowledge about research-based interventions.

By applying the TPB factors to understand the barriers to translating psychotherapy research into practice, one can reinterpret the nature of these barriers and therefore better articulate an intervention. The first barrier (i.e., clinicians' reports that research evidence may not be relevant to clinical practice) can be related to a negative Attitude toward using the evidence and to a Subjective Norm because fellow clinicians may often share these perceptions. The second barrier of poor communication between clinicians and researchers may imply low Perceived Behavioural Control because there is little opportunity for clinicians and researchers to share knowledge, and negative Attitude because both clinicians and researchers may not value each others' input enough. The third barrier, lack of cohesion among psychotherapy professionals, might indicate a Subjective Norm that does not promote cross disciplinary dialogue, and low Perceived Behavioural Control due to lack of opportunities for such dialogue.

To assess whether these TPB factors (i.e., Attitudes, Subjective Norms, Perceived Behavioural Control) affect intentions to use psychotherapy research to change practice, we surveyed a group of multidisciplinary clinicians who attended a conference on practice-based research. We hypothesised that among this group of clinicians, Attitude toward research, Subjective Norms, and Perceive Behavioural Control would be each independently and significantly associated with intention to use research to inform clinical practice.

## Method

### Context and Participants

The PPRNet (www.pprnet.ca) was launched at an inaugural conference in Ottawa in November 2012. The conference brought together clinicians, researchers, educators, and representatives of professional organisations in small focus groups to discuss barriers and opportunities to participate in the PPRNet, and to develop a preliminary list of research themes that are particularly salient to clinicians.

A preconference questionnaire was provided at conference registration to 117 individuals who were to attend the conference, and the response rate to the survey was 67.52%, with 79 individuals completing it. Respondents to the survey ranged in age from 22 to 74 years ($M = 49.38$, $SD = 12.94$). Of the 79 participants who completed the questionnaire, 68 (87.2%) practiced psychotherapy; these were the participants in this study. Direct patient contact was the predominant professional activity for 46 (67.6%) participants. The largest proportion of participants worked in independent practice (45.6%) with adult patients (89.7%) providing individual therapy (85.3%). Additional sample demographics of the 68 participants who practice psychotherapy are reported in Table 1.

### Procedure

The PPRNet Conference was advertised through several professional organisations across Canada, and it was held in Ottawa, Ontario in November, 2012. Registrants ($N = 117$) were sent a link to the online questionnaires hosted on the Fluid Surveys site shortly after they registered. Two reminder emails were sent prior to the conference to all nonresponders. Respondents provided informed consent, and the study was approved by the Ottawa Health Sciences Research Ethics Board.

### Measure: Theory of Planned Behaviour (TPB) Questionnaire

To assess participants' Attitudes, Subjective Norms, Perceived Behavioural Control, and Intention to use research, we used a modified questionnaire that was developed by Wilson et al. (2011) based on the four TPB constructs. The TPB Questionnaire consists of four subscales measuring these four constructs. The measure has a total of 14 items that are scored on a 7-point Likert scale (1 = *strongly disagree*, 7 = *strongly agree*). The original instrument

Table 1
*Demographic Characteristics of Practicing Psychotherapists Who Attended the Psychotherapy Practice–Research Network Conference*

| Characteristic | *n* | % |
|---|---|---|
| Gender | | |
| Female | 42 | 61.8 |
| Profession | | |
| Psychiatry | 11 | 16.2 |
| Psychology | 36 | 52.9 |
| Social work | 7 | 10.3 |
| Student | 4 | 5.9 |
| Other | 10 | 14.7 |
| Education | | |
| MA/MSc/MSW | 14 | 20.6 |
| MD | 12 | 17.6 |
| PhD/PsyD | 37 | 54.4 |
| Other | 5 | 7.3 |
| Primary theoretical orientation | | |
| Cognitive–Behavioural | 16 | 23.5 |
| Eclectic | 16 | 23.5 |
| Humanistic | 5 | 7.4 |
| Interpersonal | 5 | 7.4 |
| Psychodynamic | 24 | 35.3 |
| Other | 2 | 2.9 |

*Note.* $N = 68$.

was used to assess TPB constructs in adopting best practices in medical treatment settings. For this study, the items were reworded to include words and phrases like "psychotherapy" or "psychotherapy research." Example items included, "Using psychotherapy research is beneficial to my practice" for the Attitudes scale (three items); "People who are important to me think I should use psychotherapy research" for the Subjective Norms scale (four items); "Whether or not I use psychotherapy research is entirely up to me" for the Perceived Behavioural Control scale (four items); and "I intend to use psychotherapy research" for the Intentions scale (three items). The original scale demonstrated good construct validity and reliability, and has been successfully modified across several health care domains (Wilson et al., 2011). Coefficient alphas of TPB Questionnaire scales in the current sample were: Attitudes = .71, Subjective Norms = .79, Perceived Behavioural Control = .63, and Intentions = .71. This indicated adequate reliability for most scales. Coefficient alpha for Perceived Behavioural Control was low possibly due to the sensitivity of the coefficient alpha statistic to a small number of items. To assess this we calculated the mean interitem correlation, which is an alternate measure of internal consistency that is not sensitive to number of items (Clark & Watson, 1995). Mean interitem *r* for the perceived behavioural control scale was .16, indicating adequate internal consistency (Clark & Watson, 1995).

## Statistical Analyses

Multiple regression analysis was used to assess the unique association among Attitudes, Subjective Norms, and Perceived Behavioural Control (entered together as independent variables in the model), and clinicians' Intentions to use research to inform their practices (dependent variable). Data were screened for missing data and violations of assumptions prior to analysis. Sixty-three participants provided complete TPB Questionnaire data, which were used in the regression analysis.

## Results

Table 2 provides participants' means and standard deviations for the four TPB subscales. Results of the regression indicated that a significant proportion of the total variation in Intention can be accounted for by a combination of Attitudes, Subjective Norms, and Perceived Behavioural Control, $F(3, 62) = 19.41$, $p < .001$. The adjusted $R^2$ suggested a good model fit and large effect so that 47% of the variance in participants' Intention to use research to inform their practices can be explained by the three independent TPB constructs combined. To assess the unique contributions of each TPB construct, we assessed their partial correlations (*pr*) with Intentions. Partial correlations were significant for the relationship between each of the three TPB scale predictors and Intentions to use psychotherapy research: Attitudes, $pr(63) = .50$, $p < .001$; Subjective Norms, $pr(63) = .35$, $p = .005$; and Perceived Behavioural Control, $pr(63) = .28$, $p = .03$. These findings indicate a significant and unique relationship between each TPB scale predictor (i.e., after controlling for the other two predictors) and Intention to use psychotherapy research in clinical practice.

## Discussion

There is a well-documented practice–research gap in psychotherapy (Beutler et al., 1995; Boisvert & Faust, 2006; Wilson et al., 2009). However, few theories have been put forth and tested by researchers and clinicians that could inform interventions to reduce this gap. The TPB (Ajzen, 1991) has been applied in other healthcare domains to conceptualise barriers to using research (Wilson et al., 2011). In this study, we asked a group of psychotherapists to complete a TPB questionnaire prior to attending a conference. We found that Attitudes toward psychotherapy research, Subjective Norms within their peer and work groups regarding the use of research, and Perceived Behavioural Control over the implementation of research knowledge were each independently related to the clinicians' Intentions to use research to inform psychotherapy. Attitudes uniquely accounted for 25% of the variance, Subjective Norms uniquely accounted for 14% of the variance, and Perceived Behavioural Control uniquely accounted for 8% of the variance in Intentions. These findings suggest that a clinician's attitude toward research may be the largest contributor to their intention to use research. As noted previously, intentions are significantly corre-

Table 2
*Theory of Planned Behaviour Subscales: Means (M) and Standard Deviations (SD) of Items*

| Scale | *M* | *SD* |
|---|---|---|
| Attitudes | 5.45 | .87 |
| Subjective Norms | 4.63 | 1.40 |
| Perceived Behavioural Control | 5.51 | .80 |
| Intentions | 5.69 | 1.23 |

*Note.* $N = 63$.

lated with behaviours among health professionals (Armitage & Conner, 2001; Godin et al., 2008).

We acknowledge that these results might be biased because the sample of clinicians attending the conference might represent those who are already particularly attuned to the practice–research interface. Nevertheless, these findings are consistent with previous research with other health-care providers (Godin et al., 2008), and so we argue that the findings suggest that the TPB model to conceptualise barriers to using psychotherapy research may help to better understand the practice–research divide. Further, a TPB model can inform interventions that may increase the likelihood of research uptake among clinicians. One such intervention is to develop a practice research network (PRN) for psychotherapy.

## Psychotherapy PRNs: A Solution to the Practice–Research Gap?

A novel approach to overcoming barriers to translating psychotherapy research to clinical practice might involve conducting psychotherapy research in applied community and clinical settings in which clinicians inform researchers of areas important to them and their clients (Beutler et al., 1995). PRNs for psychotherapy may be one way to achieve this goal (Borkovec et al., 2001). In a PRN, community-based clinical practitioners actively collaborate with researchers to define research questions, design research protocols, and implement studies. This collaboration between practitioners and researchers is devoted to the conduct of scientifically valid effectiveness research.

An important outcome of PRNs is the collaborative relationships that can develop between clinicians and researchers, which can in turn lead to new behaviours among both groups. These collaborative relationships can go a long way to reducing barriers for clinicians to use research. Attitudes about research can be changed if clinicians feel that they have direct input into research questions, design, methodology, and reporting. In this way, clinicians' concerns about low generalizability of psychotherapy trials (Westen et al., 2004) can be diminished if they are equal partners who ensure the applicability and translation of the research findings. Subjective norms may also change among clinicians who participate in a PRN. For example, the partnerships formed with other clinicians who value research, and with researchers who value clinical input could become the new norm or new reference group for clinicians. In particular, experiencing researchers as equal collaborators and not as critics of clinician decision making could make a difference in changing these subjective norms. PRNs can provide a context for greater two-way dialogue, partnerships, and collaborations between researchers and clinicians. Finally, clinicians' perceived control of behaviour may also be affected by clinicians and researchers participating in a PRN. Clinicians who have direct input into research by collaborating with researchers may experience a greater sense of ownership of the findings and a greater sense of efficacy with regard to the science of psychotherapy. Clinicians' decisions to change practice behaviours will likely be facilitated if the decision is experienced as consistent with the practice recommendations that they helped craft through research collaboration.

A growing literature on PRNs has resulted in practice-oriented research on clinician- and client-defined helpful and hindering events in psychotherapy (Castonguay, Boswell et al., 2010), predicting treatment outcomes (Ruiz et al., 2004), and effectiveness of psychological therapies delivered in routine care (Borkovec et al., 2001). Castonguay and colleagues (2013) provide an extensive review of PRN research conducted around the world, including the Pennsylvania Psychotherapy Practice–Research Network (Castonguay, Boswell et al., 2010; Castonguay, Nelson et al., 2010). PRN research tends to be organized around common practice settings like university clinics, specific disorders like substance abuse, or professional organisations (Castonguay et al., 2013). The research typically consists of practice surveys, effectiveness studies, and some randomized trials.

PRNs are beginning to develop in Canada, with notable groups emerging in Toronto, Montreal, and Ottawa (see www.cpa.ca/aboutcpa/cpasections/clinicalpsychology/prns/ and www.mpprg.mcgill.ca). The Ottawa PPRNet, for example, was launched in 2012 and brings together clinicians, researchers, educators, and representatives of professional organisations. In November, 2012, the group developed a preliminary list of 41 research themes that are particularly salient to clinicians. These themes were gleaned from focus groups and were turned into survey items rated by clinicians. The top-rated research themes will become the bases for practice-based research that is collaboratively conceived and implemented by clinicians and researchers. The overall orientation is a deliberative priority-setting process in which clinicians and researchers jointly decide on the research agenda of the PPRNet going forward. PPRNet now has over 600 "friends" and "members," most of whom are clinicians who have indicated that they have some interest in practice-based research in psychotherapy. One of the key issues identified by clinicians at the conference was a lack of access to easily available and synthesized psychotherapy research. In response to this, the PPRNet launched a web site (www.pprnet.ca) hosted by the University of Ottawa. The web site has resources for clinicians, including links to best-practices guidelines for psychotherapy, and a monthly updated blog that synthesizes the most current research in psychotherapy with specific practice implications.

Despite our focus in this article on clinician-related barriers, the practice–research divide has two sides and it is time for researchers to take their share of responsibility for the schism. Researchers must openly invite clinicians onto research teams from the outset when research questions are defined, treatments are developed, and methods are designed. Researchers should build incentives into research grant applications to encourage clinician input, academic institutions and departments should allow for clinician partners to acquire adjunct faculty status, and funding agencies, reviewers, and journal editors should place a premium on practice-based research. This will likely require researchers to put resources into nurturing important partnerships, and to reconsider what is considered valid research and how best to translate the research into clinical practice. Clinicians have an enormous knowledge base of clinical experiences that speak to the practical aspects of defining client problems, developing and implementing interventions, and creating a therapeutic context within which clients may benefit. This practical knowledge base, which is not necessarily the purview of academic researchers, may alter what researchers consider to be important questions or methods of intervention.

In this article we took a knowledge translation and exchange perspective to understanding the practice–research gap in psycho-

therapy and to considering ways of overcoming the divide. In doing so, we redefined barriers to clinicians' use of research to inform psychotherapy from a TPB perspective, and we tested whether TPB constructs were related to clinicians' intentions to use research. Attitudes, social norms, and perceived behavioural control were each independently related to clinician intentions, and so each could be a target of intervention to reduce the practice–research divide. We described PRNs as an intervention to provide a context within which collaborative exchange can occur that may alter the way in which psychotherapists practice and the way researchers conduct their studies. By their nature, PRNs can blur the line between clinician and scientist and lead to more informed practice and translatable research.


## Résumé

En dépit de nombreuses recherches montrant l'efficacité des procédés thérapeutiques et psychothérapies fondées sur des preuves, un écart entre la pratique et la recherche persiste. Les cliniciens n'utilisent pas systématiquement les preuves pour planifier leurs traitements, et les chercheurs ne se fient pas souvent sur les connaissances des cliniciens pour étayer leurs recherches. Cet écart est en partie attribuable à des barrières identifiables. Les réseaux de recherche et de pratique en psychothérapie pourraient constituer un moyen de combler l'écart entre la pratique et la recherche. Dans le présent article, nous utilisons la théorie du comportement planifié (TCP; Ajzen, 1991) pour aider à comprendre les barrières auxquelles sont confrontés les cliniciens qui utilisent les travaux de recherche en psychothérapie. Nous avons également évalué le modèle TCP en menant une étude empirique sur 68 cliniciens qui ont assisté à la conférence sur les réseaux de recherche et de pratique ayant rempli un questionnaire TCP avant la conférence. L'attitude des cliniciens à l'égard de la recherche en psychothérapie, les normes sociales auxquelles ils sont exposés dans le cadre de leur exercice ainsi que le contrôle comportemental perçu en comparaison avec l'application de la recherche étaient chacun uniquement et significativement liés à l'intention d'utiliser la recherche en psychothérapie pour éclairer la pratique clinique. Les intentions étaient en corrélation avec le changement de comportement des professionnels de soins la santé. Nous conclurons en décrivant le développement du Psychotherapy Practice–Research Network (PPRNet) comme une approche concertée unique visant à rassembler les cliniciens et les chercheurs et à limiter les barrières par l'amélioration des attitudes, des normes sociales et du contrôle comportemental perçu parmi les cliniciens et les chercheurs. Le PPRNet contribuera à éclairer la pratique clinique et à produire des travaux de recherche en psychothérapie qui seront plus significatifs aux yeux des cliniciens et plus faciles à mettre en pratique.


*Mots-clés* : réseau de recherche et de pratique, écart pratique-recherche, pratiques exemplaires, théorie du comportement planifié, application des connaissances.

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