Involvement of front-line clinicians in clinical studies is crucial for quality marriage and family therapy effectiveness research. To identify common barriers to clinical research, 326 clinical members of the American Association for Marital and Family Therapy from three geographically diverse states were asked to describe their willingness to participate in a hypothetical research project. Therapists cited time constraints, outside limitations, client concerns, and a lack of understanding about and involvement in the study as major reasons for refusal to participate. Recommendations for building collaborative relationships between clinicians and researchers as well as future research are addressed.

Traditional clinical research in controlled settings has provided invaluable evidence for the legitimization, specifically licensure and reimbursability, of the marriage and family therapy field (Sandberg, et al., 1997). Unfortunately, this research therapy "bears little resemblance to the actual practice of [MFT and]...has had little, if any, impact on" the day to day work of most MFTs (Pinsof & Wynne, 2000, pp. 1-2). Therefore, the research needs of today have moved toward scientific investigation that can demonstrate the practicality and cost effectiveness of MFT in the "real world" with clients with varied and complex problems (Doherty, 1997, p. 5). This type of real world research is commonly referred to as 'effectiveness research' and has the potential to both build the profession of MFT and influence clinical practice.

THE GAP BETWEEN CLINICAL PRACTICE AND CLINICAL RESEARCH

Although there is an inherent link between clinical practice and clinical research, the long-standing separation between the two is well documented (Sprenkle & Moon, 1996). Both researchers and therapists have speculated as to the cause of the gap. For example, some clinicians have stated that the majority of research is irrelevant to clinical practice (Cohen, Sargent, & Sechrest, 1986), that a systems perspective is
incompatible with traditional research designs (Lebow, 1988), and that complex research methods and statistics are too difficult to understand (Heppner & Anderson, 1985). In contrast, some researchers have suggested that therapists may feel their work is effective and do not take the time to evaluate it (Shellhav, 1980), whereas others may not recognize the value of the research process and its results (Johnson, Sandberg, & Miller, 1999; Stricker, 1992). Clearly, there is a need to develop a new research paradigm that involves active collaboration between researcher and clinician (Goldfried & Wolfe, 1996; Sprenkle & Bischof, 1995).

**Barriers to Clinician Involvement in Research**

Among the reasons for non-participation suggested in the existing literature is the amount of time required by most research projects (Vachon et al., 1995). Other authors have proposed that limited familiarity with sophisticated methods and statistics serves as a barrier (Shellhav, 1980). Still, little is known regarding both the causes and potential solutions for therapists' underinvolvement in clinical research. This lack of knowledge is particularly profound in the field of family therapy, where no studies exist on MFTs' perceptions of issues preventing their participation in research.

In a previous analysis of quantitative data provided by the participants in this study (Johnson, et al., 1999), we found that the amount of research training a clinician received in his/her training program was not associated with willingness to participate in a hypothetical research project. However, research training was a significant predictor of empirical evaluation of one's own clinical work and was not significantly correlated with reading of professional journals. Results from the first portion of the project highlight possible factors that may predict clinical members' participation in various research activities. In contrast, the purpose of this analysis was to examine therapists' reasons for refusal to participate in a hypothetical research project, as well as their perceptions of what could be done to increase involvement in research and make it more applicable to clinical practice.

**METHODS**

**Procedure**

A two-page questionnaire was mailed to a random sample of 326 clinical members of the American Association for Marital and Family Therapy (AAMFT) in three geographically diverse states (New York, Kansas, and Utah). The sample was obtained from divisional AAMFT directories. A follow-up postcard was mailed 2 weeks after the initial mailing. Sixteen of the questionnaires were undeliverable because of incorrect addresses. Participants returned 130 questionnaires, but two were not completed. Thus the final sample constituted of 128 participants; the response rate was 41.3%, which is higher than most studies involving mailings to clinicians (Doherty & Simmons, 1996).

**Sample**

The gender of the sample was equally distributed, with 51.6% of the participants being female. The average age of respondents was 49.4 years. The participants represented a fairly equal distribution between doctoral- and master's-level clinicians. Sixty-one percent of master's-level therapists were female and 57.8% at the doctoral-level were male.

About one-third (37.3%) of the participants worked in private practice, 20% in group practices, 18% in university settings, and 7% worked in community mental health centers. The respondents have been practicing family therapy for an average of 13.9 years. The majority of the sample (66.4%) identified their primary professional affiliation as an MFT, but only 32.5% of the sample had obtained their degree in MFT. Data for this portion of the study were gathered only from those 52 respondents who said they would not participate in a hypothetical research project; a statistical comparison showed no significant demographic differences between this sub-sample and the larger group. Because of the questionnaire, only those respondents who said they would not participate in the project described by the vignette went on to answer additional questions regarding reasons for non-participation and to make suggestions for improving clinical research.
Measures
In the survey, the participants were presented with the following vignette:
You receive a packet in the mail requesting the participation of your clients in a research project.
You are asked to distribute a short questionnaire to your clients, encourage their participation, and
then return the completed forms in a pre-paid envelope. The confidentiality of your client is
ensured.
Three open-ended questions followed the vignette.
1. “Would you be willing to participate in this type of project? If not, explain why.”
2. “What aspect of the above example would need to be changed to ensure your participation?”
3. “In your opinion, what would make clinical research more applicable to your practice?”

Analysis
Researchers used one of the basic components of qualitative methodology, the constant-comparison
method, to analyze the data (Corbin & Strauss, 1990). Accordingly, incidents and phenomenon were
compared for similarities and differences in properties, dimensions, and processes; the researchers then
attempted to conceptualize and group similar concepts (Rafuls & Moon, 1996). Concepts that related to the
same phenomenon were grouped together to form a category, which is a higher level, more abstract
clustering of phenomena (Corbin & Strauss, 1990). The ‘naming’ of alike phenomena referred to above is
known in the literature as coding. “Codes then serve as shorthand devices to label, separate, compile and
organize data” (Charmaz, 1983, p. 111).
Corbin and Strauss (1990) described three separate stages of coding. The first stage of coding, named
open coding, is a process of breaking down the data word by word, examining, and categorizing it. Three of
the authors examined the data and independently developed a list of key phenomena and themes. In the next
stage, axial coding, the authors discussed emergent themes until a consensus regarding the category could
be reached. Thus, initial coding was later collapsed into codes of higher complexity. At the next level of the
analysis, named selective coding, two of the authors established the connection between subcategories and
categories in an effort to describe the central findings, or core concepts, of the study (Charmaz, 1983). Two
of the researchers discussed the final categories until a consensus could be reached.

RESULTS

Questions 1 and 2
Because of the similarities in the responses to the first two questions (Would you be willing to
participate in this type of project? If not, explain why. What aspect of the above example would need to be
changed to insure your participation?), the results are presented in a combined format to avoid redundancy.
Overall, the 52 participants gave 65 responses to the first question. From these 65 responses six initial codes
emerged: time restraints, outside limitations, confidentiality, risk to client, more information, and clinician
involvement. Upon further analysis and grouping by similarity, the six codes were combined to result in four
final categories. Participants also provided 53 responses to the second question. The emergent codes for
these responses were more numerous, yet similar to the first question: time/money, outside limitations,
confidentiality, risk involved, more information, relationship with researcher, involvement of therapist,
design of study. Upon further analysis, these initial nine codes were combined into four categories.
Time/money restraints. Participants consistently reported a lack of time as a major roadblock to their
participation in clinical research. A prototypical response in this area was “currently I have no free time,
too high a caseload.” In addition, respondents noted a lack of time during the actual session: “the therapy
session is too short to have time to explain the procedure to the clients.” Respondents also provided clear
requests for researchers to account for time and money factors. In short, these responses highlighted that the
time required would need to be compensated or at least carefully spelled out before some clinicians agree
to sign on.
Outside limitations. A number of clinicians mentioned that outside barriers, such as restrictions at their
employing agency, would prevent participation. An example of these concerns is that projects would have
to receive approval from a committee before a clinician could move ahead. The participants also gave feedback on potential solutions suggesting a “direct request to the research committee” or sponsorship “from within my practice association.” Responses in this category provided a clear and direct message; for some clinicians, participation in the project would depend on researchers’ willingness to work within the constraints of their particular work environment.

Client concerns. The client concerns category relates to a broad range of responses that cite issues/problems/concerns with the clients’ role in the project or its impact on them as the major reason for non-participation. The category consists of two main codes: confidentiality and risks for clients. For some respondents, participation in research appeared to be a threat to confidentiality: “I would perceive [my participation] as a breach of my function as creating a confidential, private place.” Suggestions for improvement focused on improved clarity regarding the procedures of the study and certainty regarding confidentiality concerns. Clinicians also requested this information be made available to clients as well.

In addition, numerous participants felt that the level of risk involved, both to the client and the therapeutic relationship, would influence their willingness to participate. One participant’s observation seems to summarize these concerns, “fifteen years of practice has convinced me that to contaminate the therapy with needs of the profession is not beneficial to the clients, not helpful to the therapy process.” Two specific suggestions on avoiding a negative impact were to “use former clients, people who have finished their therapy” and give therapists the “ability to exclude client[s] who are doing intense…work.” Overall, these combined responses point to the fact that the clinicians who were not willing to participate in the hypothetical project do not want research to endanger the client or interfere with the therapist/client relationship.

Understanding and involvement in the study. This fourth category represents responses relating to clinicians’ need to understand the general purposes of the study, to have some control over their level of involvement in the study, and to form a relationship with the researcher. Another area of concern is related to the level of clinician involvement. Those who wished to be left out of the research loop cited numerous reasons ranging from an unwillingness to participate in “outside” research projects to an aversion to additional paperwork (i.e. returning surveys). Other participants did not want to influence clients’ decisions regarding participation.

Suggested adjustments that could help to insure the participation of clinicians centered on forming a trusting relationship with the researcher and improving the quality of the design of the study. One comment summarizes this need well by requesting “direct contact with researchers—must be known and trusted.” Other participants noted the likelihood of participation would be increased if the proposed study was meaningful (e.g. linked to therapy), had a solid rationale, and/or was based on a good methodology. For example, one candid respondent stated s/he wanted “better measures—something that is obviously not just for someone to get a cheap article/dissertation.” Another stated that studies need to have “some connection to my client population.”

Question 3

Overall, the 52 clinicians provided 95 responses to this crucial and timely question (in your opinion, what would make clinical research more applicable to your practice?) These responses yielded nine different codes: Time and resources, outside limitations, involving relevant topics, design and methodology, outcomes and effectiveness, easy reading, personal responsibility, easy participating in research for therapist, easy participating in research for clients. After further analysis, the nine codes were combined into categories.

Time and convenience. The time and convenience category highlights the need for time to participate in and read clinical research. As one respondent noted “time to read needs to be set aside. The practicality of the workload, number of clients, and little administrative support” makes it hard. According to these respondents, it appears that support for carving out time for research related activities would help make it more applicable to practice.

The second and third codes in this category suggest that participating in research must be easy for clinicians and clients. Comments in this area show a need for “opportunities to participate in research that
can be readily and practically carried out" and also for "readily available [assessment] batteries" that can be "built into the ordinary and usual paper work." Similarly, one comment stated that "instruments with simple administration, that were more focused, [and] did not take so long for patients to take" would be very helpful. In short, responses suggested that convenience for clients and therapists was a major issue.

Clinically and professionally relevant studies. Respondents clearly and consistently stated that research must be more relevant to their own clinical work and the needs of the profession. Comments in this area ranged from a call for studies on specific topic areas (depression, violence, divorce adjustment, gender issues, religion, race and cultural differences), to more focus on the application of studies to everyday clinical problems. One candid therapist suggested that research would be more applicable if someone would "take away incentives for professors to publish irrelevant pieces of crap so they can make tenure." Also, there was a stated need for outcome and effectiveness research. Responses in this area reflected a call for "more information on what strategies are effective with what problems and which population." Some of these clinicians wanted to become more familiar with "clinical outcome measure[s]" and the "most effective strategies for change."

Personal and professional barriers. This category represents comments related to roadblocks in the work setting or personal struggles that need to be overcome for research to be more applicable to clinical practice. Some clinicians felt that it would help "if they were in a group of colleagues or a clinic which do[es] research" or "if managed care would insist on it" or if "our agency research and program evaluation department [did not] take care of most of [the research]." Other clinicians recognized barriers within themselves: for example, stating research "would be more applicable if I read more of it. It should be more important to my practice than it is" or I am not doing "my part to apply clinical findings to practice."

Design and presentation of study. This final category is comprised of comments regarding the way studies are conceptualized and designed and how they are written. In order for these studies to be more relevant to clinical practice, the responding therapists called for "well designed studies" that are "theoretically grounded" and use a "better [method for] conceptualization and operationalization." In addition, some participants want "less quantitative reports that are not helpful [because] group means don’t speak for individuals" and a "greater acceptance and publication of qualitative research studies."

Therapists also expressed their desire for articles that are "easier to read, to digest". There was also a frequent call for "more readings like FT Networker, less reading like JMFT", "less statistics, more narrative", and "shorter articles" with a "better writing style." It was also suggested that "summaries of relevant findings" be published in "a brief newsletter" like other professional associations. This proposed publication could discuss the "implications for therapy of the latest findings" so clinicians would not have "to wade through study after study...[because] it's too hard." In summary, the clinicians in this study displayed a strong desire for more clearly written, concise summaries of relevant research findings.

DISCUSSION

With a current emphasis on effectiveness and progress research at numerous government agencies, these timely findings provide valuable information on what prevents front line clinicians and researchers from collaborating in clinical research (Doherty, 1997; Pinsof & Wynne, 2000). Therefore, the real value of these results lie in their ability to highlight a group of therapists’ suggestions on how to increase the likelihood of clinician involvement in clinical research, as well as how to make that research more applicable and relevant to practice.

Addressing the Issue of Time

These findings are congruent with previous research that names a lack of time as a principle barrier to clinical research (Shelhav, 1980; Vachon et al., 1995). Also, the clinicians’ responses contained numerous potential solutions. Such as shorter surveys that can be completed outside of the therapy session or as a natural part of it (Roszkowski & Bean, 1990). Clinicians also requested succinct instructions, clearly specified time requirements, and even pay for their extra time and effort. It is clear from these findings that researchers should consider and address the cost (time and money) required for participation in their study in an effort to increase the likelihood of response.
The Researcher–Clinician Relationship: Towards Collaboration

One significant finding from this study was the need for researchers to gain the clinician’s trust through activities such as providing personal information, contacting the therapist by phone, or presenting qualifications necessary to conduct the study. In addition to these initial steps, researchers can build collaborative relationships by finding out how research can be tailored to benefit the clinical practice of participating clinicians. Models of collaborative and mutually beneficial relationships among groups with differing, yet complimentary goals already exists in behavioral health care settings (Hepworth, Gavazzi, Adlin, & Miller, 1988; Seaburn, Lorenz, Gunn, Gawinski, & Mauksch, 1996). Clinicians can learn from these examples of collaboration where combined efforts towards common goals benefit care recipients and providers from multiple fields.

The results from this study provide intriguing suggestions on how these relationships can be formed. For example, some clinicians in the study mentioned they would like to be consulted in the design of the study so they could share their extensive experience and practical knowledge. As an “insider”, these clinicians could be active, contributing participants, and not merely distributors of questionnaires. Other comments suggested researchers recruit therapists who have a previous interest or expertise in the area under investigation. Common interest and shared commitment to a particular presenting problem or population can serve as a strong foundation upon which a mutually beneficial research program is built. It has been our experience that these collaborative relationships require more than shared interests, they require shared space and time as well (Sandberg, 1999). Where possible, visits to clinics or research offices, lunches, and co-authored presentations and papers are activities that can build the types of relationships that lead to collaborative family therapy research. Furthermore, this type of collaboration will be more likely to meet the needs of the multiple stakeholders in FT research (e.g. clinicians, clients, insurance companies, funding agencies) (Doherty, 1997).

Applicability and Relevance

The responses from the clinicians clearly highlighted a need for more research on the particular problems (depression, violence, divorce adjustment, racial and cultural issues, etc.) and populations (children, families, couples) with which they work. The respondents also noted that research would be more applicable to clinical practice if it could “reflect what is really happening in the field”. Even those studies that do relate directly to the day to day practice of therapy appears, to a number of clinicians in this study, to be written in a “dry and boring” or overly complex way. Numerous additional responses called for more research updates that are easy to read and directly related to clinical practice. One articulate suggestion was made that more “overviews of what works and what doesn’t...or 'summaries of previous findings'...[be published] to make quick sense out of research.” The results of this study suggest that even the most relevant clinical research may not be applicable to practice unless it is shorter and more easily digested than traditional clinical research articles.

Implications for Future Research

Future research must be able to move beyond two limitations of the current study. First, it should be noted that the data from this portion of the study comes only from those who said they would not participate in the vignette, but did respond to the overall study. The purpose of this project was to assess why clinicians do or do not participate in clinical research. Therefore, there is a serious concern that due to non-response bias, we were not able to capture the experience of the very clinicians we were seeking (the non-responders). Future researchers must find ways to follow up with those who refuse initial participation. Only by capturing the perspective of this sub-sample can the research questions be answered.

Second, the study is limited by the lack of specificity of the vignette presented to the therapists. The fact that the topic, purpose, and type of research project were unknown to the therapists made it more difficult for some to make a decision regarding participation. In this study, it was impossible to assess which types of research designs or levels of clinician involvement are least preferred. Future research would be benefited by a detailed description of the proposed study that could elicit a more rich description of potential barriers from the clinicians.
In addition, future research on the topic of barriers to researcher-clinician collaboration would do well to focus on success stories. Specifically, in-depth case studies of mutually beneficial, collaborative relationships where clinically relevant and applicable research is the major outcome would be of great value. Then, the conversation could move beyond identifying problems to the successful application of solutions.

REFERENCES


