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Board editorial: Psychological therapies and *or* as transformational research?

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In research cultures there is, I believe, a pervasive fear of anything lacking intellectual precision. In this context accounts of research into mental health and illness, and health in general for that matter, tend towards a cautious and defensive stance, giving the reader the impression of a practitioner/researcher who is more organised and coherent than is actually the case (Freshwater, 2003). Mental illness is not a neutral, value free, scientifically precise term, which begs the question: How can it be researched as such? Research is often invoked as a method of establishing whether or not it is necessary to provide a service, which service to provide, or how to measure the efficacy of a service. However, the huge amount of research conducted into areas such as psychological therapy over and during the last 40 years has, to a large extent, at least until recently, failed to influence the design of services or treatments. Where research has demonstrated that a particular type of treatment would benefit patients, NHS service providers have not always ensured that the necessary skill base is developed and appropriate funding ring fenced. One such example of this is the strong evidence that the therapeutic relationship is the *sine qua non* of successful therapy; a relationship that requires time, energy and effort to cultivate. And yet, most often, the focus of psychological therapies research centres around the effectiveness of short-term interventions such as cognitive behavioural and psychosocial skills. Proponents of such therapies now usefully contest the long held belief that short-term psychological therapeutic interventions do no prize or emphasise the importance of the relationship continues to be challenged by such research studies as presented in this focus issue on contemporary psychological therapies research.

We are all, by now, familiar with the idiom 'what counts cannot always be counted'. It is of course rightly argued that evidence for advanced practice must be based on research, and that this research must be scientific, which means that it should be objective, ideally assuming a quantitative approach. Furthermore, anything worthwhile that is subjective is covered by qualitative approaches, which might be included as research evidence – if they can prove they are scientific. The philosopher Kierkegaard (1941) argued that objective thought translates everything into results and helps all mankind to cheat, by copying these off and reciting them by rote. Public consensual knowledge of mental illness is based, by and large,

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on knowledge not of the internal (subjective) state of the individuals, but of their overt manifestations. It is the external events that are generally objectified and researched through, in the main, scientific medical model approaches. And we call this 'sane'! An approach to research that attempts to capture the efficacy of an intervention that is delivered subjectively through an individually cultivated therapeutic relationship, by objectifying the relationship and treating it as a possible variable! I am exaggerating, of course, not simply to make a point, but rather to ask a question. Or perhaps several. How far have we travelled in the last 40 years in developing and implementing a service that provides high quality psychological therapies as a possible intervention for all those who wish to access it? And what difference are those therapies and associated services making to the individual, to the health service, to the community and to society at large.

Interestingly the findings of a research study gathering evidence to measure the efficacy of psychological therapies might recommend that this type of patient would benefit from that type of therapy; an intense period of being in a relationship with another person who is willing and qualified to listen to the patient. Paradoxically the research itself could have been the therapy, but instead it tends to perpetuate the objectification of the client. As Rolfe (2002: 180) pointed out a decade ago: 'Typically, in research the generalisability or external validity of a research study is maximised by suppressing the individuality of the research subjects and, in effect, presenting them as research objects, as decontextualised examples or representatives of some greater whole'. From this point of view and in harmony with Buber (1958) the relationship between researcher and researched is one of the I–It rather than I–Thou. So where are we four decades later? Well, maybe that is a question for you, the reader of this focused edition, to reflect on.

In my own reflections and in the work of a team of researchers over a period of years we have identified three principal approaches to research in the disciplines that include psychological therapies, which we believe have evolved over the last 100 years, and whilst I run the risk of creating yet another typology or something that can be interpreted as such, it is interesting to plot the development of research into psychological therapies and specifically in the era of (post) evidence based practice! In the first approach the evidence gathered is based on the analysis of counselling and psychotherapy *outcomes* (see, for example, literature that includes work by Roth and Fonagy, and McLeod and Hemmings). This approach is sometimes referred to as the 'scientist–practitioner' approach and is derived from practices and procedures in allied professions such as psychology and medicine. It is often the case that publicly funded and market orientated therapy agencies have to provide some evidence of efficacy using this methodology. In the second approach the evidence gathered is based on the analysis of the *process* of therapy sessions, rather like the definitive work of Carl Rogers at Ohio State University in the 1940s and at the University of Chicago in the 1950s, involving the detailed analysis of sessions with a view to identifying the therapeutic attitude and interventions which are therapeutically efficacious. This approach includes the design of measures to evaluate the nature of the client response to therapist attitudes and interventions. Still, this type of research is more often than not undertaken by qualified researchers and not necessarily by the practitioners themselves, and normally adopts similar practices to those of psychology. The third approach, which is more novel and therefore perhaps more challenging, is based on the reflexive analysis of clinical experience, what is often referred to as the 'practitioner–researcher' approach, and aims to work in the space that is the research–practice gap. This approach to research and evidence gathering is critically relevant to current public

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debates about healthcare, since some commentators have argued that problems have arisen because academically trained health professionals have not been able to integrate their knowledge with everyday practice. Such evidence arises out of the practice of therapy itself, and is possibly relevant and familiar to a larger number of practitioners. As Lees (2001) notes, historically it is the largest single type of writing in the profession. Importantly, the approach builds on the principles of therapeutic practice with questions emerging out of the research process itself and data collection being based on the practitioner's experience of their practice and/or some other aspect of his/her professional development. The research process in this context is an extension of this ongoing process of reflection in training and continuing professional development, and rather like therapeutic practice the aim of the research is to bring about change and transformation rather than producing a set of results. The experience of transformation through and as a result of the process of research is reciprocal and requires, as already indicated, a high degree of reflexivity, mental agility and flexibility. Essentially the willingness to discover and be discovered.

Defining reflexivity as understood in the research process is not simple; definitions are neither unanimous nor harmonious, arguably mirroring the concept of reflexivity itself. And as with reflection, there are a number of reductionist and formulaic views of reflexivity, in addition to those that are culturally linked. Delanty (2000), however, takes issue with this, arguing that reflexivity is 'reducible neither to agency nor to structure'. The same could be said of individuals and of research approaches, Nevertheless, what is important here is that we understand the inextricable relationship between knowing self and knowing other and the way in which that interaction helps us to understand better the efficacy of our psychological intervention.

I have introduced another concept here, that of interaction. The consulting room in any therapeutic encounter consists of two human beings who have strong feelings about each other, and as such 'the practitioner (researcher) needs to be more than an interpreting machine' Lomas (2001: 3). Reciprocity is uncommon in research relationships and is usually rejected as unscientific due to it biasing the findings (Oakley, 1981). I have argued along with others that the research process requires a new conception, one in which bias is accepted as a naturally occurring phenomena in all human interactions. Reciprocity on behalf of the researcher means that something has to be given back to the researched. The researcher needs to be asking questions such as: What is the benefit to the client? What may be of benefit is simply being listened to, acknowledged and made visible. Active listening can and does provide something of value; it demonstrates commitment, attention, respect and authenticity. 'These conditions transcend the data collection to become a therapeutic encounter in its own right' (Rolfe, 2002: 184).

The papers in this issue highlight the complexity of human interaction and of understanding and interpreting the nature of effective psychological interventions in any meaningful way. What I hope to have provided in this editorial is fruitful ground for ways in which you interact with the papers and researchers, patients, practitioners and outcomes contained in the words on the page. That you are caused to look up in the act of reading; to return to yourself and to allow yourself to be transformed through that reading. This will, I hope, lead to the eventual emergence of a more coherent description of the interaction between research into mental health and the mental health of researchers and practitioners.

For mental illness is not remarkable in the current zeitgeist, rather what is remarkable is people's ability to maintain some sense of mental health and mental stability.

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