The Counselling and Psychotherapy Research Handbook

Edited by Andreas Vossler and Naomi Moller

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Setting the scene: Why research matters

Dr Andreas Vossler (Open University),
Dr Naomi Moller (Open University) &
Prof. Mick Cooper (University of Roehampton)

Introduction – towards a more research-oriented profession

At the beginning of this book you might wonder why there is a need for a whole handbook on research in counselling and psychotherapy, or more generally, why research matters so much in a field full of engaged and skilled trainees and practitioners focused on their work with clients in the therapy room. Both can be seen and understood in the context of a remarkable shift towards a more research-oriented profession in the field of counselling and psychotherapy in recent years (see, for example, Rowan, 2001), with a dramatic rise in the importance attributed to research evidence. Where once this was a relatively neglected backwater of the field, research findings are now an increasingly important factor in decisions about which forms of counselling and psychotherapy, as well as which services and practitioners, get funded (Cooper, 2010). For example, therapists who work within the Improving Access to Psychological Therapies (IAPT) programme in the UK are required to offer *only* those psychological therapies for clients with depression and anxiety that are empirically supported and endorsed by the guidelines of the National Institute for Health and Clinical Excellence (NICE). NICE provides guidance based on the best available evidence, not only for counselling and psychotherapy, but also for other health and social care professionals (there are, for example, NICE treatment guidelines for physical ailments such as diabetes).

However, it is not enough today for practitioners to be able to cite research evidence that the approach they are taking with their clients is effective. Within the National Health Service (NHS) and other professional settings practitioners are now under growing pressure to demonstrate *both* research awareness and competence. They are expected to be aware of a range of research methodologies, and to be able to evaluate research and other evidence to inform their own practice. In other words, there is an increasing assumption that counsellors and

psychotherapists will be both consumers and producers of research (Stratton, 2007). As such, the move towards a more research-oriented profession has led to mounting pressure on counsellor and psychotherapy training programmes to incorporate research competencies and skills into their curricula, with the future of the profession seen as depending on the successful education of research-savvy practitioners (Wheeler & Elliott, 2008). The United Kingdom Council for Psychotherapy (UKCP), the main accreditation agency for psychotherapists, released new Standards of Education and Training in 2012. These standards require trainees to develop an ability to critically evaluate research reports and findings, and to understand basic research techniques to investigate and evaluate psychotherapeutic interventions (UKCP, 2012). Correspondingly, the British Association for Counselling and Psychotherapy (BACP), as the chief accreditation body nationally for counsellors, has also made research a required component of training ('Gold Book', released in 2009). BACP training standards require training programmes to be research-informed and students not only to develop a broad critical understanding of research findings, but also basic competencies in small-scale research projects (BACP, 2009).

In this introductory chapter we will explore the reasons behind the increased emphasis placed on research and the corresponding move towards a more research-oriented profession. We will discuss why counsellors and psychotherapists should engage with research about what they are doing, and we will help you to understand why research really matters in counselling and psychotherapy. The chapter will set the scene for this book – and we hope it will infect you with enthusiasm for the journey through both the book and your own research.

Activity 1.1 Reasons for being engaged with research

Why should counsellors and psychotherapists engage with research? Spend 10 minutes writing a list of reasons why you think it is important for trainees and practitioners either to be informed about research or to be doing research themselves.

Comment

It will be helpful to revisit and update your list of reasons throughout the book. This will help you see if you can identify other/different motivations to engage with research, and develop a feeling for your personal objectives in relation to research.

Evidence-based practice and practice-based evidence

The increasing influence of science in all areas of our life over the last century (see also Chapter 2) is undoubtedly a major driving force behind the push for

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empirical proof of the value of counselling and psychotherapy. In our days, it is not enough anymore for counsellors and psychotherapists to say to policy-makers, commissioning agencies and clients, 'Oh, we know that what we are doing is helpful for our clients, so please give us your money for our service'. And you will probably agree that it shouldn't be enough, given that a snake-oil salesman in the Wild West would have said exactly the same when praising the health-promoting effects of his fraudulent goods.

'I know he SAYS he can do all that stuff but where is the PROOF?'

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Today, funding bodies – from government agencies, health providers, employers to private individuals – are more like critical consumers. To justify their expenditures they want to see concrete evidence for the service they are buying into. In this 'evidence-based' world (Cooper, 2011), practitioners and service providers are now required to prove the beneficial effects of their work with reliable evidence derived from rigorously conducted research. In this context, there are fears that those therapeutic approaches and modalities without supporting empirical evidence 'may soon find themselves permanently outside the health care system' (Wheeler & Elliott, 2008, p. 133).

When critically considering what is seen as evidence that a particular therapeutic approach 'works', it is useful to understand something about the historical development of the current perspective on 'evidence-based practice' (EBP). The EBP movement emerged in the 1980s and has since been strongly promoted in the NHS context in the UK. It originated in the practice of medicine and can, in theory, be applied to almost any aspect of health care (Bower, 2003). As defined by the American Psychological Association, evidence-based psychological practice is concerned with the 'integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences' (APA, 2006, p. 273). In evidence-based practice in counselling and psychotherapy, all therapeutic work should be informed by and based on empirical evidence produced by rigorous scientific studies. As a treatment is only considered as effective if there is sound evidence from multiple, reliable sources, the EBP framework has been the driving force for numerous research studies, which aim to establish an evidence base for psychological therapies (Barkham & Mellor-Clark, 2003).

It is important to be aware that the medical understanding implicit in the EBP model means that certain types of research are seen as 'better' than others. The research design that is prioritised within the EBP movement is the randomised controlled trial (RCT), often seen as the 'gold standard' method to investigate the efficacy of a treatment or intervention in outcome research ('Does a treatment work?'). RCTs are credited with the ability to identify the 'potency of an intervention, as assessed under highly controlled conditions' (efficacy) (Bower, 2003, p. 320) in an objective and reliable manner (National Collaborating Centre for Mental Health, 2010). This is the reason why clinical guideline groups, such as NICE and SIGN (Scottish Intercollegiate Guidelines Network), tend to base their clinical recommendations on RCT evidence rather than on alternative sources of information, such as other types of research design, routine outcome data or clinical experience (Grimes & Schulz, 2002). Basically, an RCT is a research experiment in which participants are allocated to two or more different groups or 'conditions' – usually a particular treatment (e.g. cognitive behavioural therapy) versus another treatment (e.g. humanistic therapy) and/or a no treatment group (waiting list, placebo). Information box 1.1 provides more details on this kind of research

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design adopted from medical and pharmaceutical science as it is typically operationalised in counselling and psychotherapy research.

Information box 1.1 Randomised controlled trials

You have a client who you believe has benefitted from therapy – your evidence is the difference in some measure of client functioning before and after therapy. However, with only pre- and post-therapy measures it is not possible to prove *that any improvement in symptom levels and other outcome criteria are due to the received treatment. For instance, it might be that the psychological problems simply improved over time, entirely without any impact from the counselling you provided (Eysenck (1957) referred to this as 'spontaneous remission'). Alternatively, other factors outside therapy might have been responsible for the changes measured (e.g. the client got a new job or fell in love). In fact, if you want to show that counselling or psychotherapy is responsible for a desired effect (in other words, that the intervention is 'efficacious'), what you need to do is to compare changes in two clients groups: clients who have undergone therapy (the treatment group) with individuals who have not undergone therapy (a 'control group'). If you find more change in the treatment group compared to the control group at the end of the intervention, then you can be fairly certain that it is the treatment they have received that is responsible for the changes, and not any other factors. The data that goes into the statistical analysis in this kind of quantitative research is typically client ratings of their symptomology before and after treatment.*

There are some basic principles in planning and conducting RCTs aimed at minimising or controlling possible influences on client improvement other than the therapeutic intervention(s) being studied. This is to ensure that any outcome differences between the conditions can be attributed to the therapy effect only.

Randomisation

If you are comparing groups in an RCT, it is important that they are as similar as possible (e.g. on average, equally depressed) so that any difference you find is due to the intervention (treatment/no treatment) and not to group differences. Hence, in RCTs, participants are allocated randomly to the different conditions. While it is acknowledged that some differences will inevitably exist between the groups, randomisation is still seen as the best method in ensuring that these differences between the groups are minimal.

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Homogenisation of samples

RCTs are usually highly selective in recruiting their participants. Potential participants are screened to maximise homogeneity of diagnosis (e.g. only unipolar depression) and minimise co-occurring (comorbid) conditions (e.g. depression and anxiety) that could increase variability of the response to the treatment (Westen, Novotny & Thompson-Brenner, 2004).

Manualisation of treatment

The involved practitioners are supposed to deliver the counselling or psychotherapy intervention following a particular 'manual' of practice (i.e. a therapy manual with specific prescriptions or general practice guidelines). Sessions are usually recorded and assessed for 'adherence' to ensure that the therapy is delivered according to the manual. All this is done to avoid, as much as possible, variation between therapists so that all participants in a particular group receive exactly the same intervention/treatment. It also makes it less likely that any differences are due to the therapists rather than the treatment being studied.

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How do you feel about RCTs and the evidence they produce? Is this a suitable research methodology for something as complex as counselling and psychotherapy? What do you think are potential pros and cons of RCTs in this context?

Evidence-based practice and research with the RCT methodology has certainly helped to build a body of practice that promotes the adaption of proven interventions in everyday practice (Bower & Gilbody, 2010), giving a clear statement of all scientific evidence to date in different clinical areas. However, one thing to keep in mind when reading this book and going on your own research journey is that every research methodology has its weaknesses and limitations, and RCTs are no different in this respect. In fact, due to the reification of RCTs as the 'gold standard' in counselling and psychotherapy research, there has been rigorous debate about their positives and negatives (see, for example, Cooper, 2011; Rawlins, 2008; Schmitt Freire, 2006; Westen et al., 2004). There is not space here to rehearse all of the arguments made, but the

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main problem associated with the application of RCT methodology is that the kind of therapy carried out in these studies can bear little relationship to the real world of therapeutic practice (e.g. McLeod, 2013). For example, due to strict inclusion criteria (e.g. if the research is focused on depression, researchers will exclude clients with comorbid conditions such as anxiety), the client samples used in these studies are often not representative of clients seen in real-world settings. The closely controlled design, with its adherence to a treatment manual, also undervalues factors which have been shown to influence therapy outcome in practice settings, such as the personality and competence of the therapist (Baldwin & Imel, 2013), client motivation (Bohart & Greaves Wade, 2013) and the strength of the therapeutic relationship (Norcross, 2011). In addition, the symptom-focused outcome measures that are used in RCT research are not able to capture some perspectives on therapy outcome relevant in real-world settings, such as client experiences and satisfaction (e.g. Elliott & Williams, 2003). It is therefore no surprise that many practitioners are sceptical about this kind of research; they feel that manualised therapy in a controlled, experimental RCT setting is not mirroring the 'messiness' of their everyday therapeutic practice, and they are generally reluctant to engage with RCT methods (e.g. Rogers, Maidman & House, 2011; Storr, 2011). Another problem is that conducting an RCT is quite expensive and time-consuming, making it impossible to finance this kind of study on all potential treatments and client groups (McLeod, 2013).

In reaction to the weaknesses and limitations associated with the EBP paradigm, an alternative yet complementary programme of research has emerged in the last two decades – the 'practice-based evidence' movement (PBE). This also mainly quantitative approach is rooted in practice settings (e.g. UK primary care setting) and aims to collect data by implementing routine data collection procedures with standardised measurement and evaluation systems – in other words, systematically collecting data from all clients in a setting so as to enable research into the effectiveness of the counselling conducted in that setting. An UK example of such a measurement system is the Clinical Outcomes in Routine Evaluation – Outcome Measure (CORE-OM) (Mellor-Clark, Connell, Barkham & Cummins, 2001). Data can be collected before and after counselling, at intervals through the therapy or session-by-session, and there is usually no control over sample or service provision (all clients and practitioners are included and no particular treatment model is prescribed). Data from various sites can be pooled together to build an evidence-base on the provision of counselling and psychotherapy in routine practice (Barkham, Hardy & Mellor-Clark, 2010). Large, practice-based data sets were, for example, collected in the context of both the CORE (National Dataset) and IAPT initiatives, and the analysis of this data found substantial pre-treatment to post-treatment improvements independent of the treatment approach (Stiles, Barkham, Mellor-Clark & Connell, 2008). This type of research is clearly important politically as it potentially allows some

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therapeutic approaches which do not have strong evidence from RCTs to demonstrate that they are effective in actual practice.

The aspiration with the PBE movement is to integrate research with practice and 'reprivilege the role of the practitioner as a central focus and participant in research activity' (Castonguay, Barkham, Lutz & McAleavey, 2013, p. 98). For this reason the PBE approach is very relevant for this book and more information on the PBE approach and the methods and procedures to collect practice-based evidence from real-life settings can be found in Chapter 10 on 'Quantitative Methods' and Chapter 18, 'Next Steps'.

Despite the tensions between the paradigms of evidence-based practice and practice-based evidence (Nathan, Stuart & Dolan, 2000), both types of research have the potential to complement each other (Barkham & Mellor-Clark, 2000). EBP takes a 'top-down' approach in researching the *efficacy* of an intervention under 'ideal' controlled conditions, and findings from these studies inform national treatment guidelines for practitioners. PBE follows a 'bottom-up' approach in monitoring the *effectiveness* of counselling and psychotherapy in everyday practice and routine, clinical contexts. Neither paradigm alone is sufficient to build a robust knowledge base for the counselling and psychotherapy profession (Barkham & Margison, 2007). As well as knowing what difference therapy *can* make (its efficacy), it is also important to establish what *actual* difference it makes (its effectiveness). Hence, both types of research are needed to enhance and develop the practice of counsellors and psychotherapists and to demonstrate the value of their work.

Beyond outcome research

Both traditions of research discussed thus far focus on the *outcome* of therapy. However, an important strand of counselling and psychotherapy research concerns *process* research, research that focuses on *how* therapy works rather than whether or not it does (McLeod, 2010a). Furthermore, both EBP and PBE typically use quantitative data and involve statistical analysis to draw their conclusions. But there is a growing and important body of qualitative research in the counselling and psychotherapy field (McLeod, 2013). In addition, the focus of quantitative research is *nomothetic*, which generalises from groups of individuals to the broader population, as opposed to *idiographic*, which is focused on understanding the particularities of individual experience. Yet there is also a long-standing tradition of psychotherapy research that focuses on understanding individual clients. Thus, while this chapter stresses the political and economic importance of PBE and EBP research, we do not want to give the impression that these are the only types of research that matter for the field. Actually, in times of financial hardship it can become more and more difficult to find external funding for large-scale RCTs undertaken by specialist researchers. Consideration of these restraints has led McLeod (2013, p. xii) to suggest that 'in the future, sustainable programmes of

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inquiry will be based in grassroots projects in which research data are generated as a by-product of routine practice'.

When investigating therapy practice, and here especially the lived experiences of both clients and practitioners, researchers can choose from a range of research methodologies. With the chapters on qualitative methods (Chapter 12 and 13) and case study methodologies (Chapter 14 and 15) we will introduce the main alternatives to the quantitative research paradigm. Being appropriately equipped to engage in different kinds of practitioner research can be seen as one motive for counsellors and psychotherapists to learn about research in the field. In the following, we will have a closer look at this and other important reasons to be or become research-savvy.

Reasons to engage with research

So what exactly are the reasons why research matters for the profession, and why should trainees and practitioners become research-knowledgeable and active? A whole variety of motives have been put forward in the debate around a stronger research-orientation (e.g. Barkham & Barker, 2010; Cooper, 2008; McLeod, 2013). We have clustered some of the most salient arguments into three thematic groups, starting with the moral argument that counsellors and psychotherapists really need to make sure that their clients are not harmed or damaged by their work.

Moral argument: Research provides insight into the client perspective and helps to prevent counselling from damaging clients

Based on their knowledge of theory and their own perception of their work with their clients, many trainees or practising therapists may feel that they already have a good insight into their clients' experiences, and that their clients benefit from their work. However, there is evidence that counsellors and therapists are in fact not always good at judging their work, or how clients experience it. This poor practitioner judgement almost certainly contributes to the 20% of clients who state problematic or harmful experiences in therapy (Levy et al., 1996), and the 5–10% who deteriorate during counselling or psychotherapy (Cooper, 2008).

- Walfish, McAlister, O'Donnell and Lambert (2012) looked at a sample of 129 privately-practising psychotherapists and asked them to rate their own skill and performance level relative to others in their profession. 25% of the sample felt their skills placed them in the top-performing 10% compared with their peers, and none viewed themselves as below average. This self-assessment bias is consistently found in the literature.

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- There is only a moderate agreement between therapists' and clients' ratings of the quality of the therapeutic relationship (e.g. Gurman, 1977; Tyron, Blackwell & Hammel, 2007), which suggests that often therapists and clients are not in sync in their view of the therapeutic alliance.
- Therapists tend to underestimate the importance of relational, as opposed to technical, aspects of therapy. In addition, they only agree with clients in 30–40% of instances on what was most significant in therapy sessions (Timulak, 2008a), suggesting a lack of client and therapist agreement on what is or is not working in counselling.
- Michael Lambert's recent research (2010; Lambert & Ogles, 2004) shows that therapists are often not very good at predicting the outcomes of therapy (i.e. they do not reliably know when it is going well or badly). Lambert was also able to demonstrate that systematically giving therapists client feedback on the therapy process helps to improve outcomes.

In the face of this evidence, counsellors and psychotherapists have a moral duty to make sure that what they think is doing good actually is doing good. While in many situations trainees and practitioners are well advised to trust their own intuitive sense of what clients are experiencing, they should be aware that they are not immune from misperceptions and misjudgements. Research can help in this context to see counselling and psychotherapy from the clients' perspective and to understand what they are really going through. Brief research tools and questionnaires can be used to collect feedback on the progress of therapy, not only for research projects but also in routine practice. This information can be utilised by practitioners to review the therapy process and make sure they are on track with their work (McLeod, 2013; see also Chapter 10). Such a practice is in line with the increased focus on the importance of the service user's perspectives and experiences to improve treatment quality in the NHS context (NICE, 2011).

Financial argument: Research can prove the value of counselling and psychotherapy

As described above, practitioners feel more and more pressure to demonstrate the quality and benefits of their service as they are held accountable to clients and funding bodies. Knowing what the research says about the efficacy of the service provided can help counsellors, psychotherapists and service providers to communicate and promote their work, and help consumers understand the value of what it is that they do.

This financial argument has been highlighted in the UK by the high-profile Depression Report (Layard, 2006), which analysed the extent of anxiety, depression and other 'mental health problems' in the population and their impact on incapacity benefits. While mental health services may be 'Cinderella services' (under-funded and under-valued) that are likely to be under threat in difficult economic times, Lord Layard's report provided the government with a clear and

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convincing economic case for investing millions into the provision of evidence-based psychotherapy to reduce the benefit bill for the state. Layard's report and the resulting Improving Access to Psychological Therapies (IAPT) programme (DH, 2007; www.iapt.nhs.uk/) can be seen as an example of how research findings can be used to evidence the value of counselling and psychotherapy services and get the government investing in this area.

Professional argument: Research can improve the therapeutic work and help trainees and practitioners grow professionally

Research findings can provide trainees and practitioners with useful orientation and guidance in situations when they are not sure how to proceed. Similarly, trained practitioners who struggle in their work with a particular client group or presented problem can turn to research findings to learn more about client needs or the best ways of working with certain problems (e.g. the default therapeutic stance for a problem). Research findings can also help to avoid practices and approaches which are actually harmful (Barkham & Barker, 2010). In sum, research provides guidance in the absence of or in addition to other information (such as experience, intuition and theoretical concepts).

Research can also be valuable in challenging implicit assumptions and preconceptions about therapeutic work. Some study findings have the potential to push counsellors and psychotherapists to reconsider the way they think about their clients and the best way to work with them. The Information box below provides you with a personal example of how the belief system of one of the chapter authors was shaken by a research report, helping him to be more responsive to the actual client in front of him.

Information box 1.2 Research can challenge assumptions (from Cooper, 2008, p. 3)

Mick:

'As someone trained in existential psychotherapy [...], my tendency in initial sessions had always been to warn clients of the limits of therapeutic effectiveness [...]. I did tend to adopt a rather dour stance, emphasising to clients that therapy was not a magic pill and highlighting the challenges that it was likely to involve. Then I came across a research chapter by Snyder and colleagues (1999) which showed, fairly conclusively, that the more clients hoped and believed that their therapy would work the more helpful it tended to be.

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How did I react? Well, initially I discounted; but once I had a chance to digest it and consider it in the light of some supervisory and client feedback, I came to the conclusion that, perhaps, beginning an episode of therapy with all the things that might not help was possibly not the best starting point for clients. So what do I do now? Well, I don't tell clients everything is going to be fine the moment they walk through the door; but I definitely spend less time taking them through all the limitations of the therapeutic enterprise; and if I think that therapy can help a client, I make sure that I tell them that.'

Mick's example nicely illustrates how research can stimulate and encourage self-reflection and help to improve therapeutic work – if we are open and willing to consider its messages. And more than that, trainees and practitioners can carry out their own research to find answers for the 'burning questions' (McLeod, 2013, p. 5) that have emerged from their professional practice, or their professional journey. Engaging with research and getting answers to these questions can contribute to personal and professional development and help to consolidate our professional identity (as illustrated below, with the two personal examples from the editors of this book).

Information box 1.3 Engagement with research

Andreas:

In my practice as a family therapist, the integration of children and young people in the therapy sessions seemed to be a particular challenge. Some children displayed turbulent, fidgety and unruly behaviour during the therapy sessions so that it was at times quite hard to work with them in this setting. Others were afraid of the unfamiliar, adult-dominated family counselling situation, making it difficult to establish a working relationship with them. And many teenagers were initially unwilling to participate in a counselling process with their parents, sometimes trying to boycott the conversation in the counselling room.

These kinds of experiences led me to question the way children and adolescents may feel in counselling sessions: are their needs and interests considered appropriately by us professionals? These considerations constituted my motivation to investigate young people's experiences in child guidance and family counselling with a qualitative study (Vossler, 2004).

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Naomi:

As a tutor on courses which utilise personal development groups, I was struck by the sometimes very negative reactions expressed by some students to the groups. I think I was surprised by this in part as a result of having had group therapy for about two years, which I found very helpful. Group therapy taught me things that I had not learned in years of personal therapy, mostly about how I relate in and to groups, and how my experience in my family growing up continues to play out. As a result of my own positive group experience, I had not questioned the idea that having personal development groups as part of training might be useful, nor had I really thought about the theoretical arguments for their use. I began by talking with my colleagues on the courses – why did they think personal development (PD) groups were important? – and went on to read theory on personal development broadly in counselling and psychotherapy and on PD groups in particular. After that I went looking for research and found that there was not much. So I decided, with a student, to do some research. What we found helped me decide that the theoretical rationale for PD groups in training is still under-developed and that trainers needed to be more aware of the potential negatives as well as the potential positives of these groups (Moller & Rance, 2013).

Conclusion – let the research journey begin

The aim of this chapter was to introduce the current field of research in counselling and psychotherapy and help you to understand why research matters for the practical work with clients, and for the profession more generally. We also hope that we were able to encourage you to engage with research and start your own research journey. If you want to keep up to date with the latest findings in the counselling and psychotherapy field, look at some of the suggestions we make in Chapter 18.

Going forward

This book is designed as a 'travel guide' for your own research journey. It will provide you with a comprehensive introduction to research methods and process within counselling and psychotherapy. It will take you step by step through the different stages of a research process, providing you with enough applied knowledge on selected methodologies to support you with your own research projects. In doing so, the book will focus on the common questions and concerns of practitioners and trainees around research.

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PAUSE FOR REFLECTION   LOOKING FORWARD

Looking at the book content, do you feel prepared for your journey through the book and your own research? Which chapters do you think will be particularly helpful and which are you unsure about? Is this all new for you or do you already have some research knowledge and experience which you can consider as you read the chapters?

Ambivalences and uncertainties towards research can be a stumbling block at the beginning of the research journey. The next chapter will therefore focus on these concerns and suspicions, and encourage you to reflect on the images and fantasies you have about research.

Suggestions for further reading

Cooper, M. (2008). *Essential Research Findings in Counselling and Psychotherapy: The facts are friendly*. London: Sage.

Comprehensive introduction to research findings in the field of counselling and psychotherapy.

McLeod, J. (2013). *An Introduction to Research in Counselling and Psychotherapy*. London: Sage.

Accessible starter text introducing the basic principles of research theory and practice.

Timulak, L. (2008b). *Research in Counselling and Psychotherapy*. London: Sage.

This book provides a presentation of counselling and psychotherapy research genres.

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