Research & Practice in Gestalt Therapy: Promoting the Dialogue

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Like most of us, my interests have shifted over the 2 years since I proposed this talk.

Research-Practice dialogue-integration as a career theme.
Research-Practice Gap in Psychotherapy

- Old problem: Morrow-Bradley & Elliott (1986) – and others – have documented:
  - Practitioners rarely use research to guide practice
  - Therapists learn from supervisors, clients, experience, not research

- General problem of knowledge dissemination: Medicine, engineering etc., etc
Likely Sources of Research-Practice Gap: *Practice Side*

- Busy lives/Work pressures
- Fear/threat to preferred ways of working
- Complexity of practice/role of context
- Unresolved bad experiences with research during training
Likely Sources of Research-Practice Gap: Research Side

- Value on simplification/generalization
- Boring/difficult/inaccessible presentation
- Topics irrelevant to practice
  - Unrepresentative client populations
  - Manualized treatments
  - Psychodynamic, humanistic-experiential, family, integrative therapies underrepresented
What Research are Therapists Interested in?

- Morrow-Bradley & Elliott (1986) again:
  - Specific effective therapeutic processes
  - Particular client populations/situations
  - Clients with challenging processes (e.g., personality difficulties)
  - Therapeutic difficulties
  - Case studies
  - Qualitative studies

= In general, what is specific, relevant and difficult
Research and Practice as Different Worlds

- Researchers and practitioners have different needs and live in different “worlds”
  - Even when they are the same person!
- Simplicity vs. Complexity
- Generalization vs. Context
- Reflection vs. Action

- But…
Research and Practice Can Support Each Other

1. Practice can **justify research** (introduction sections & grant proposals)
   
2. Practice can be a **source for research** (Stiles: Researchers “consume practice” as a source of inspiration by operationalizing and testing ideas that emerge from practice)
   
3. Research can **justify practice** (example: psychotherapy meta-analyses)
   
4. Research can **help practitioners** do a better job (apply findings, concepts, methods)
Principles for Practice-based Research - 1

- (1) Make research relevant to actual practice of therapy
- (2) Use methods that support therapy rather than interfere with it
- (3) Actively and continuously involve therapists in selection of research questions and methods
Principles for Practice-based Research - 2

- (4) Include inexpensive and easy-to-use instruments of key elements
  - E.g., Therapeutic alliance, client problem severity
- (5) Encourage variety of research methods
  - Qualitative & quantitative; group & single-case
- (6) Create research networks of training sites using similar, pan-theoretical instruments
A List of Research Methods that Can Bridge Research & Practice

- Systematic qualitative research methods
- Second generation systematic case studies
- Outcome monitoring methods
- Newer, powerful psychometric methods
- Conceptual frameworks for designing practice-based research protocols
- Virtual communities & online data collection platforms
- Significant events research
- Conversation analysis
Research & Practice in Psychotherapy: A Personal Account

- Scenes (and sequences) from a therapist-researcher career
Scenes from a Therapist-Researcher Career: 1

(1) 1970’s PhD research: the painful gap:

- I love research/the joy of knowing/learning all the ways I can find to know
- But: Sometimes this feels so far away from my lived experience of struggling to become a half-decent therapist
Scenes from a Therapist-Researcher Career: 2

My first attempted solution: Do research as close as possible to the lived experience of psychotherapy

- Interpersonal Process Recall (IPR)
- Record sessions & play them back for client and/or therapist soon after session
  - Actual process
  - Inner experience of clients & therapists
- Hundreds of hours interviewing clients and therapists about their experiences in sessions
- => Made me who I am as a therapist
1976: While carrying out my PhD research study on clients’ experiences of therapist response modes,
I accidentally came upon the following bit of therapy…

[Play IPR45 clip]
“That in your hands” Episode²

C1: Well, you know when we talked about ‘hh Hhh (7.5) my basic feeling of having something rea:lly wro:ng (2.0) with me during that long time span that [C’s son] ‘h was uhh sick and (sniff) (2.5) t the only psychiatrist I was seeing at the time (1.5) rea:lly thought I had something to do with it, ‘h (4.0) well, I just really felt convinced (T: Yeah) h that I could hurt somebody (1.5) hh, but since we’ve talked about that, I wouldn’t be surprised but ‘hh that realization hasn’t just given me some kind of freedom. Hehh (2.0).

T1: I mean I’m so deeply moved when you say that myself that I can, I feel myself near tears, because I think you’re [with emphasis] right on (1.0), really right on (2.0).

C2: I think that’s why when ‘hh I cut that tooth that needed just extensive work, ‘h and it wound up not only being, you know, save the
tooth, but that it was actually beautiful restoration, it must have given me a lot of confidence that, OK, not only did I not ruin it, but boy, I really fixed it up. (T:mm) I wonder (1.0).

T2: Yeah, °gee° (1.0).

C3: I know that almost—it’d be the natural thing when you’re first using a high speed drill to have natural fears about ruining the tooth cause (eh) (that) really can do a lot of damage in a short time (1.5). But then, you know, that’s just a natural concern which you can sort—really quickly reassure yourself isn’t likely, if you’re at all careful (1.5), and I even observed this one guy I told you about who did keep having pulp exposures and it didn’t see(h)em to (h) e(h)ven bo(h)ether him. He—see, it was part of the learning experience—and I kept saying, “I don’t do that and I stil(h)l feel horrible—Why?” (1.0) And I think that was was it (he) (.5).
• T3: °Yeah,° that in your hands was the power, ‘h (1.0) (h)to(h) ma(h)ke [C’s son] into an autistic kid, to really ruin him, to have heard that (1.5), I guess, I guess, that was there (2.0).
C4: t After all that time (.5).
T4: Right (.5).
C5: Kin(d of a)ma:zing. Huhh (12.0) Huhh (<.5).
T5: How do you feel (C: ‘Hhh) know about that? (C:Hhh wh—) I mean, what you said (C:Hhh) to me before made me wondering, it’s as if somehow you’ve gotten control of that thought (1.0), t or that feeling or, or you’ve s—, you can just look at it in a much more realistic way, right?=
C6: Yeah, I think so ‘h ‘tisn’t so much control as just uh (2.5) it came ou:t into the o:pen (1.0). I had plenty of time to f:eel it (3.0), and it just (3.5) stack it up beside the facts huh (1.0) ‘h and see that that wasn’t really tru:e (T: mhm) it wasn’t true then, isn’t true now (T:mhm) ‘h hh (2.0). I remember I really felt it, just felt it at the time we were talking about it (4.0), and since then I’ve felt more comfortable (heuh)....
Scene 4 (montage): Inspired by this striking therapy event, and a conversation with Les Greenberg in 1977, I then spend the next 15 years of my career figuring out how to identify, assess, and analyse such significant events:

- **Identification**: Helpful Aspects of Therapy (HAT) Form
- **Assessment**: Brief Structured Recall (Elliott & Shapiro, 1987)
- **Analysis**: Comprehensive Process Analysis (CPA; Elliott 1989; Elliott et al., 1994)
Scene 5: The Black Hole of Process Research

- Eventually, I discover that I need to understand a universe in each significant moment
  - From the atoms of each meticulously transcribed sound
  - To the end of therapy (and beyond!)
  - And back to the client’s childhood and the therapist’s training in order to explain a moment in therapy

- The method threatens to collapse under its own weight

- Nevertheless, I am prepared to spend the rest of my career doing CPAs on EFT events…
Then Something Happened that Took Me Off Track…
The Evidence-Based Practice Movement

- Early 1990’s: American psychologists, worried about the rapid spread of anti-depressant medications, proposed adapting US Federal Drug Administration standards for approving new medications to identifying “Empirically Validated Treatments” (EVTs)
- By 1996, the name had been softened to “Empirically Supported Treatments” (Chambless, 1996)
- Later: “Evidence-Based Practice” (EBP; APA, 2006)
- 1998: German Commission (Grawe et al)
- 1999: National Institute for Clinical Excellence (NICE) established in the UK
Reactions to Evidence-Based Practice Movement

- Caught humanistic-experiential psychotherapists and others by surprise
- Many argued that it was biased and unscientific
- In fact, there have always been many obvious problems with EBP, but…
- Focusing only on challenging validity of EBP movement left us behind during a period of rapid developments
1992-93: Greenberg, Lietaer & I were invited to contribute a chapter on humanistic-experiential therapies for fourth edition of Bergin & Garfield’s *Handbook of Psychotherapy & Behavior Change*. We decided to do what we’d always sworn we would never do…

A meta-analysis of all research on HEPs

This first meta-analysis eventually grew into a monster, and spawned two other related meta-analyses.
“Here’s a list of 100,000 warehouses full of data. I’d like you to condense them down to one meaningful warehouse.”
HEP Outcome Meta-analysis: The First Generation

- Greenberg, Lietaer & I fought the process the whole way:
  - First: We only analysed pre-post effects:
    - Found: large effects
    - Bergin & Garfield argued that this didn’t prove that therapy caused these effects
  - Second: We analysed (a) controlled & (b) comparative studies
    - Found: 5 times as much change in HEPs vs no-treatment
    - Found: No difference between HEPs and other therapies
    - Bergin & Garfield argued that CBT could still be better than HEPs
  - Third: We broke down types of HEP vs CBT
    - Found: No difference between Person-Centred and CBT
    - Found: EFT had larger effects than CBT
    - Bergin & Garfield stopped arguing with us & accepted the chapter
    - Better still: We have developed a method for analyzing outcome studies using three lines of evidence
### Scene 7 (Montage): The HEP Meta-Analysis Project

<table>
<thead>
<tr>
<th>Authors</th>
<th>Year</th>
<th>N of studies</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Elliott</td>
<td>1996</td>
<td>63</td>
</tr>
<tr>
<td>3. Elliott</td>
<td>2002</td>
<td>86</td>
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# Meta-analyses of Humanistic-Experiential Psychotherapy Outcome Research

<table>
<thead>
<tr>
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<tbody>
<tr>
<td></td>
<td>K Studies</td>
<td>N Clients</td>
<td>M (95% CI)</td>
</tr>
<tr>
<td>Pre-Post effect sizes (ES) in HEP samples</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall (combined follow-up periods):</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Primary Outcomes (PO)</td>
<td>--</td>
<td>--</td>
<td>--</td>
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<tr>
<td>All Outcomes (All)</td>
<td>199</td>
<td>14,032</td>
<td>.93 (.88, 1.04)</td>
</tr>
<tr>
<td>By follow-up time period:</td>
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<td></td>
<td></td>
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<tr>
<td>Post (0 – 1 mo post):</td>
<td>181</td>
<td>13,109</td>
<td>.95 (.86, 1.04)</td>
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<tr>
<td>Early follow-up (2–11 mos.)</td>
<td>77</td>
<td>2125</td>
<td>1.05 (.90, 1.20)</td>
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<tr>
<td>Late follow-up (12+ mos.)</td>
<td>52</td>
<td>2611</td>
<td>1.11 (.93, 1.29)</td>
</tr>
<tr>
<td>By type of HEP (combined follow-up periods)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supportive-Nondirective</td>
<td>32</td>
<td>704</td>
<td>.80 (.63, .97)</td>
</tr>
<tr>
<td>Person-Centered</td>
<td>76</td>
<td>10,450</td>
<td>.95 (.83, 1.04)</td>
</tr>
<tr>
<td>Emotion-Focused</td>
<td>34</td>
<td>1138</td>
<td>1.21 (.104, 1.37)</td>
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<tr>
<td>Gestalt/Psychodrama</td>
<td>17</td>
<td>723</td>
<td>.78 (.57, .98)</td>
</tr>
<tr>
<td>Other HEPs</td>
<td>53</td>
<td>1605</td>
<td>.89 (.69, 1.10)</td>
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Side Trip: A Quick Look at the Gestalt Therapy Studies in the Two Meta-analytic Samples
Sample 1 Pre-post effects: 1947-2008 (k = 21)

<table>
<thead>
<tr>
<th>Study</th>
<th>Effect Size</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Beutler 1991</td>
<td>1.424</td>
<td>Focused Expressive</td>
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<tr>
<td>Beutler 1984</td>
<td>.926</td>
<td>Gestalt expressive experiential</td>
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<tr>
<td>Cross 1982</td>
<td>1.203</td>
<td>Insight tx based on TA &amp; gestalt principles Primal gestalt tech used</td>
</tr>
<tr>
<td>Dahl 1983</td>
<td>1.065</td>
<td>Insight tx based on TA &amp; gestalt principles Primal gestalt tech used</td>
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<tr>
<td>Felton 1973</td>
<td>.932</td>
<td>Gestalt classroom program</td>
</tr>
<tr>
<td>Foulds 1970a</td>
<td>.803</td>
<td>experiential-gestalt growth group</td>
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<tr>
<td>Foulds 1971a</td>
<td>.789</td>
<td>experiential-gestalt growth group</td>
</tr>
<tr>
<td>Foulds 1971b</td>
<td>.574</td>
<td>experiential-gestalt growth group</td>
</tr>
<tr>
<td>Foulds 1976</td>
<td>.682</td>
<td>Gestalt marathon</td>
</tr>
<tr>
<td>Foulds 1977</td>
<td>.703</td>
<td>Gestalt workshop</td>
</tr>
<tr>
<td>Greenberg H 1978</td>
<td>.561</td>
<td>Marathon</td>
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Sample 1 Pre-post effects: 1947-2008 (k = 21), cont

<table>
<thead>
<tr>
<th>Study</th>
<th>Effect Size</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jessee 1981</td>
<td>2.979</td>
<td>Gestalt couples tx</td>
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<tr>
<td>Johnson W 1976</td>
<td>2.414</td>
<td>Gestalt</td>
</tr>
<tr>
<td>Little 1986</td>
<td>.833</td>
<td>Gestalt Family tx</td>
</tr>
<tr>
<td>Martinez-FT 2002</td>
<td>.810</td>
<td>Gestalt grp full tx</td>
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<tr>
<td>Martinez-RRP 2002</td>
<td>1.231</td>
<td>Gestalt stimulus role play</td>
</tr>
<tr>
<td>Martinez-SRP 2002</td>
<td>.840</td>
<td>Gestalt response role play</td>
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<tr>
<td>Serok 1983</td>
<td>.514</td>
<td>Gestalt grp tx</td>
</tr>
<tr>
<td>Serok 1993</td>
<td>2.827</td>
<td>Gestalt grp tx</td>
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<tr>
<td>Tyson 1987 gestalt</td>
<td>.691</td>
<td>Gestalt grp tx</td>
</tr>
<tr>
<td>Yalom 1977</td>
<td>.226</td>
<td>Gestalt weekend group</td>
</tr>
<tr>
<td><strong>Weighted Mean ES</strong></td>
<td><strong>1.04 (.76,1.33)</strong></td>
<td>$Q = 60.7; \Gamma^2 = 72%$</td>
</tr>
</tbody>
</table>
Study | Effect Size | Std. Error | Weight | Weight (%)
--- | --- | --- | --- | ---
Beutler FNP | 1.42 | 0.33 | 2.04 | 5.23
Beutler 1984 | 0.33 | 0.24 | 2.77 | 5.06
Cross1982 | 1.20 | 0.39 | 2.19 | 4.70
Dahl 1983 | 1.07 | 0.42 | 2.09 | 4.50
Falton 1973 | 0.93 | 0.39 | 2.94 | 6.32
Foulds 1970a | 0.80 | 0.24 | 2.29 | 5.32
Foulds 1971a | 0.70 | 0.28 | 2.64 | 5.66
Foulds 1971b | 0.57 | 0.28 | 2.24 | 4.61
Foulds 1976 | 0.68 | 0.25 | 2.75 | 5.91
Foulds 1977 | 0.70 | 0.27 | 2.66 | 5.71
Greenberg & 1978 Marathon | 0.56 | 0.29 | 2.57 | 5.52
Jesse 1981 | 2.98 | 0.39 | 2.19 | 4.71
Johnson W 1976 | 2.41 | 0.57 | 1.59 | 3.62
Little 1986 | 0.83 | 0.47 | 1.92 | 4.10
Martinez-F 2002 | 0.81 | 0.52 | 1.73 | 3.71
Martinez-KP 2002 | 1.23 | 0.54 | 1.69 | 3.63
Martinez-SHP 2002 | 0.84 | 0.53 | 1.73 | 3.70
Sokol 1969 | 0.51 | 0.49 | 1.85 | 3.58
Sokol 1993 | 2.93 | 0.55 | 1.66 | 3.55
Tyson 1987 gestalt | 0.69 | 0.44 | 2.00 | 4.29
Yalom 1977 | 0.23 | 0.30 | 2.55 | 5.47
Overall | 1.04 | 0.15 |
Sample 2 Pre-post effects: 2009 - 2018 (k = 11)

<table>
<thead>
<tr>
<th>Study</th>
<th>Effect Size</th>
<th>Description</th>
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<tbody>
<tr>
<td>Butollo 2016</td>
<td>1.116</td>
<td>Dialogical exposure therapy</td>
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<tr>
<td>Butollo 2014</td>
<td>.980</td>
<td>Dialogical exposure therapy</td>
</tr>
<tr>
<td>Carlson, Tamagawa 2017</td>
<td>.278</td>
<td>Gestalt</td>
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<td>Cho 2011</td>
<td>.764</td>
<td>Gestalt group therapy</td>
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<tr>
<td>Compare 2013a&amp;b</td>
<td>1.814</td>
<td>Gestalt</td>
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<td>Hagl 2015</td>
<td>.570</td>
<td>Dialogical exposure therapy</td>
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<tr>
<td>Kraljevic 2011</td>
<td>.106</td>
<td>Integrative Gestalt Therapy</td>
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<tr>
<td>Leung 2013</td>
<td>.526</td>
<td>Gestalt-oriented growth workshops</td>
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<tr>
<td>Leung 2017</td>
<td>.508</td>
<td>Gestalt</td>
</tr>
<tr>
<td>Schulthess 2016</td>
<td>.717</td>
<td>Gestalt</td>
</tr>
<tr>
<td>Stevens 2011</td>
<td>1.188</td>
<td>Gestalt</td>
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<tr>
<td>Weighted Mean ES</td>
<td>.81 (.52, 1.10)</td>
<td>Q = 48.8; I² = 80%</td>
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</tbody>
</table>
Forest Plot

Effect size of each study
Estimated overall effect size
Estimated overall confidence interval

Study
Butollo 2016
Butollo et al
Carlson, Tamagawa
Cho
Compare 2013a&b
HAGL DES
Kraljevic
Leung
Leung
Schulthess
Stevens

Overall

Model: Random-effects model
# Meta-analyses of Humanistic-Experiential Psychotherapy Outcome Research

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<td></td>
<td>K Studies</td>
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</tr>
<tr>
<td>Controlled ES: HEPs vs. untreated participants</td>
<td></td>
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<tr>
<td>Controlled effects overall</td>
<td>62</td>
<td>4102</td>
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<tr>
<td>Controlled RCTs</td>
<td>31</td>
<td>1146</td>
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<tr>
<td>HEP pre-post</td>
<td>59</td>
<td>2144</td>
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<tr>
<td>Untreated Control pre-post</td>
<td>53</td>
<td>1958</td>
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<tr>
<td>Comparative ES: HEPs vs. NonHEPs</td>
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<tr>
<td>Comparative studies overall</td>
<td>135</td>
<td>1348</td>
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<tr>
<td>RCTs only</td>
<td>113</td>
<td>5552</td>
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<tr>
<td>HEP pre-post</td>
<td>97</td>
<td>5975</td>
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<tr>
<td>NonHEP pre-post</td>
<td>122</td>
<td>6985</td>
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</table>
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<td>K Studies</td>
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<td>M (95% CI)</td>
<td>K Studies</td>
</tr>
<tr>
<td><strong>Comparative ES: HEPs vs. Specific</strong> NonHEPs</td>
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<tr>
<td><strong>HEPs vs. CBT</strong></td>
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</tr>
<tr>
<td>Overall</td>
<td>77</td>
<td>9041</td>
<td>-.17 (-.25, -.09)</td>
<td>36</td>
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<tr>
<td>RCTs</td>
<td>66</td>
<td>2833</td>
<td>-.17 (-.27, -.07)</td>
<td>32</td>
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<tr>
<td><strong>HEP vs. non-CBT</strong></td>
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<td></td>
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<tr>
<td>Overall</td>
<td>58</td>
<td>4444</td>
<td>.17 (.08, .27)</td>
<td>27</td>
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<tr>
<td>RCTs</td>
<td>47</td>
<td>2719</td>
<td>.15 (.03, .28)</td>
<td>24</td>
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<td><strong>Different HEPs vs CBT</strong></td>
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<tr>
<td>PCT vs. CBT</td>
<td>22</td>
<td>6956</td>
<td>-.06 (-.11, -.01)</td>
<td>10</td>
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<tr>
<td>Supportive-nondirective vs. CBT</td>
<td>37</td>
<td>1466</td>
<td>-.31 (-.45, -.17)</td>
<td>23</td>
</tr>
<tr>
<td><strong>Comparative ES: More vs less intensive/ process guiding HEPs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall</td>
<td>9</td>
<td>294</td>
<td>.14 (-.21, .50)</td>
<td>6</td>
</tr>
</tbody>
</table>
Three lines of **converging evidence**:

- **Pre-post effects**: How much do clients change over therapy?
  - Answer: A lot

- **Controlled effects**: Do clients use therapy to cause themselves to change?
  - Answer: Yes

- **Comparative effects**: Are HEPs as effective as CBT?
  - Answer: It’s complicated…In general, yes, but with exceptions, eg, PCT < CBT in latest sample
Speculations about the Latest Outcome Findings

- Elliott et al, 2021:
  1. Smaller sample of studies & clients (results less reliable, easier to skew)?
  2. Fewer positive researcher allegiance studies (couldn’t control for these)
  3. Has CBT gotten more effective?
  4. Have CBT researchers gotten better at skewing the results in their favour?
  5. Is recent research focused on more challenging client populations (e.g., coping with chronic medical conditions) that HEPs is not so good with (or is less developed for)?

But for me, the question remains: Can we do better as HEP therapists?
Scenes from a Therapist-Researcher Career

- Scene 8: Mid-1990’s:
  - Dissatisfaction with political meta-analytic research
  - Need to work with a bigger unit than significant events
  - => Systematic single case research
  - Had an EFT research clinic with nice data & diverse client population
  - Had to come up with a memorable topic for my SPR presidential address
Second Generation Systematic Case Study Research (McLeod, 2010)

- Some brand names:
  - Pragmatic case study (Fishman)
  - Hermeneutic single case efficacy design (HSCED) (Elliott)
  - Adjudicated case study (Bohart)
  - Later: combined HSCED + adjudication

- Suitable for practice settings/practice-based research
Systematic Case Study Approaches: Central Guiding Stance

- Alternative formulations:
  - “Disciplined inquiry” (Peterson, Fishman, Messer)
  - “Critical reflection” (Elliott)
  - “Quasi-judicial” (Miller) or “adjudicated” (Bohart, Elliott)

- All suggest:
  - (a) careful, systematic use of method, and
  - (b) attempts to prove favored assumptions wrong
Quality Standards for Systematic Case Studies (McLeod, others)

- Availability and use of complete records of treatment
  - E.g., Recordings, detailed process notes
- Use of multiple sources of data
  - E.g., Client, therapist, observer
- Use of multiple kinds of data
  - E.g., Psychometric measures, process/content ratings, descriptive, interpretive
- Use of multiple researchers or auditors
- Systematic assessment of client, therapy outcome and process
- Grounding of conclusions in data
- Careful examination of alternative descriptions and explanations
Hermeneutic Single Case Efficacy Design

- “Hermeneutic” = a fancy word for interpretive
- “Efficacy” = a fancy word for causal
- Inspired by Art Bohart’s work
- Pronounced “H-sked”
- Combines legalistic and theory-testing methods
Three Key Questions in HSCED

(1) Did the client **change** substantially over the course of therapy?
   - How much?; How sure are you? (probability: 0 – 100%)
   - Also: How and in what ways, in what time course did change occur?

(2) If the client changed, did therapy make a substantial contribution? (**causality**)
   - How much?; How sure are you? (probability: 0 – 100%)

(3) If the client changed, what brought about those changes? (**change processes**)
   - Moderator variables: Relevant background characteristics of client that affected outcome
   - Mediator variables: Processes during therapy period that brought about change
HSCED: Basic Principles

1. **Thick description**: Use multiple data collection methods (mixed quantitative-qualitative) to construct a rich data record.

2. **Hermeneutic**: Systematically weigh and interpret evidence, develop explanations for change.

3. **Critical**: Make good-faith efforts to find support for non-therapy explanations.

   Use qualitative & quantitative data to complement, clarify & interrogate each other.
4. **Practicality**: Use easily-implemented, “off-the-shelf measures” (preferably free)

5. **Quasi-judicial procedure**: Actively adopt affirmative vs. skeptic positions to clarify evidence (same person or different teams of researchers)

6. **Flexibility**: Use creativity to adapt methods to particular situation, e.g.,

   - **Relaxed standard of proof**: “Probable cause”; “Reasonable Assurance” ($p < .2$); “Near certainty” ($p < .05$ or $p < .01$) may be over-kill

   - Use **broad definition of “cause”**; include intentions, offering opportunities...
Steps in HSCED’s Practical Reasoning Strategy

1. Assemble rich case record:
   Multiple data sources, qualitative/quantitative

2. Evaluate possible links between therapy and client change
   = Affirmative case

3. Critically evaluate alternative nontherapy explanations
   = Sceptic case
Overview of HSCED process

- **Client & Therapist**: Therapy
- **Researcher**: Data collection (rich case record)
- **HSCED Investigator**: Affirmative case, Sceptic case
- **“Judges”**: Adjudication

The process involves collaboration between the client and therapist, data collection by the researcher, investigation by the HSCED investigator, and adjudication by the judges.
Rich Case Record: Example

- Basic descriptive information (demographics, diagnoses, problems, therapy approach)
  - Quantitative outcome measures
  - Weekly outcome measure (e.g., Personal Questionnaire)
  - Change Interview (qualitative)
  - Helpful Aspects of Therapy (HAT) form (client; significant events)
  - Records of therapy sessions (tapes, therapist process notes)
I. Client PE-111: “George”:
Excerpts from his Rich Case Record


- Go to: http://strathprints.strath.ac.uk/16829/

**Description of Client**
- 61 year-old European-American male
- Married; some college
- Retired; former security administrator

**Psychosocial History**
- Emotional and physical abuse
- Suicide attempt as teenager (drove car into quarry)
- Estranged from 2 of 3 children
- Wants to move to SW United States; frustrated that wife won’t
George: Presenting Problems and Diagnosis

- Presenting problem: Panic attacks; primarily on expressway (4 yrs)
- Fear of heights, boating, and excessive speed
- Interpersonal difficulties due to “abrasive personality”
- Main treatment goal = to cross bridges
- Axis I [based on Structured Clinical Interview for DSM-IV]
  - Panic Disorder w/ Agoraphobia; also Specific Phobia
  - Major Depressive Disorder, In Full Remission
  - Alcohol Dependence, Sustained Full Remission
- Axis II: None (but “features”)
PERSONAL QUESTIONNAIRE

Today's Date: ____________ Session: _______

Instructions: Please complete at the beginning of each session. Rate each of the following problems according to how much it has bothered you during the past seven days, including today.

| Case # PE-111 Your Initials: ___ |

<table>
<thead>
<tr>
<th></th>
<th>Not At All</th>
<th>Very Little</th>
<th>Little</th>
<th>Moderately</th>
<th>Considerably</th>
<th>Very Considerably</th>
<th>Maximum Possible</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I have a fear of driving on the expressway.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>2. I'm not able to interact w/ relatives and acquaintances.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>3. I have a fear of heights.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>4. I have a fear of excess speeds.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>5. My personality is too abrasive.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>6. I have a fear of boating.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>
Session 1: Presentation of problem
George: Therapy

- **23 sessions**: Client terminated by own choice; regarded treatment as successful
- **Emotion-Focused Therapy (EFT)**
  - Integration of Person-Centered & Gestalt therapies
- Research Clinic, University of Toledo, Ohio, USA
- **Therapist** – 50 yrs. old; experienced EFT therapist; one of originators of approach
  - Research team: Affirmative and Skeptic teams of 2 clinical psychology grad students each
2. Outcome analysis: Session 23 video
II. Outcome analysis:

- Use weekly change measure & one other
- 1. Make table showing:
  - Clinical cut-off level ("caseness") (e.g., CORE-OM: 1.25)
  - Reliable change minimum value (CORE-OM: .5)
  - Client pre-counselling value
  - Client post-counselling value
  - Indicate which values are (a) in the clinical range, and (b) show reliable improvement or deterioration
- 2. Make graph showing weekly outcome measure scores
## George: Quantitative Outcome Data

<table>
<thead>
<tr>
<th></th>
<th>Case-ness Cut-off</th>
<th>$RCI_{Min. \ (p &lt; .2)}$</th>
<th>Pre-Tx</th>
<th>Post-10</th>
<th>Post-Tx</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCL-90</td>
<td>.93</td>
<td>.51(-/+)</td>
<td>.77</td>
<td>.56</td>
<td>.57</td>
</tr>
<tr>
<td>IIP</td>
<td>1.50</td>
<td>.57(-/+)</td>
<td>1.96</td>
<td>1.46</td>
<td>2.27</td>
</tr>
<tr>
<td>PQ</td>
<td>3.00</td>
<td>1.00(-/+)</td>
<td>4.33</td>
<td>5.33(-)</td>
<td>4.83</td>
</tr>
</tbody>
</table>

IIP: Inventory of Interpersonal Problems (L. Horowitz)
PQ: Personal Questionnaire (Shapiro, Elliott)
**Bold:** In clinical range (> caseness)
(-/+): Reliable negative/positive change from pre-therapy
Considerable distress

Caseness threshold (Little distress)
# George’s Changes at Post-Tx Interview

<table>
<thead>
<tr>
<th>Change:</th>
<th>Expectancy</th>
<th>How Likely w/o Tx</th>
<th>How Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can cross bridges now</td>
<td>Very surprised by</td>
<td><strong>Very unlikely</strong></td>
<td>Extremely important</td>
</tr>
<tr>
<td>Better relationship with wife</td>
<td>Very surprised by</td>
<td>Neither likely nor unlikely</td>
<td>Extremely important</td>
</tr>
<tr>
<td>More tolerant</td>
<td>Somewhat surprised by</td>
<td><strong>Very unlikely</strong></td>
<td>Moderately important</td>
</tr>
<tr>
<td>Less afraid of flying</td>
<td>Very surprised by</td>
<td>Neither likely nor unlikely</td>
<td>Very important</td>
</tr>
</tbody>
</table>
III. Evaluating Therapeutic Influence: Change Process Analysis

- Looking for 2+ kinds of evidence for connections between what happened in counselling and outcome:

- Types of Evidence:
  1. Changes in stable problems: Quantitative/qualitative changes from pre to post, plus information about how long client has had problem
  2. Sudden gains within therapy (big changes from one week to the next)
  3. Change Interview (ratings of changes; attribution question; helpful aspects)
  4. HAT descriptions of significant events (Helpfulness: 7+)
1. Change in stable problems

<table>
<thead>
<tr>
<th>Change:</th>
<th>Corresponding Problem</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can cross bridges now</td>
<td>Fear of expressway/heights/speed [=Bridges]</td>
<td>2 – 5 yrs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5 – 10 yrs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 – 5 yrs</td>
</tr>
<tr>
<td>Better relationship with wife</td>
<td>Problems with relatives/Abrasive</td>
<td>10+ yrs</td>
</tr>
<tr>
<td>More tolerant</td>
<td>Problems with relatives/Abrasive</td>
<td>10+ yrs</td>
</tr>
<tr>
<td>Less afraid of flying</td>
<td>Fear of flying</td>
<td>2 – 5 yrs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5 – 10 yrs</td>
</tr>
</tbody>
</table>

**Conclusion**: The George showed change on at least some of his stable problems
**2. Sudden Gains? Not really...**

Considerable distress

Caseness threshold (Little distress)

**Conclusion:** No evidence for therapy bringing about change here.
3. Change Interview: George’s Post-Therapy Account of What Helped Him

- Very general, focused on therapeutic relationship:
  - Emphasized nature of relationship with T:
    - T is “a good man”
    - Interactions as pleasant, harmonious
    - T did not intrude past C’s personal boundaries
    - T expressed personal pleasure in C’s progress
  - T helped C develop a new, broader, more tolerant perspective on others, life
3. Change Interview: George’s Post-Therapy Account of What Helped Him

- **Conclusion**: George described helpful aspects of therapy, attributed some of his changes to therapy (“would not have happened without therapy”).
4. HAT Descriptions: George’s Highest-Rated Significant Therapy Events - 1

*Session 4, extremely helpful (“9”): “When (therapist) mentioned that my childhood experiences could have a direct bearing on my problems now. Never thought of it as having anything to with my fear of bridges…”

[=> related to post-therapy Bridge crossing change?]
Session 4: Unfolding/Emotion Regulation/ Trauma work
4. George’s Highest-Rated Significant Therapy Events

- **Session 6, extremely helpful:** “The part where I talked to my daughter [empty-chair work]. Found out she is one of the bridges I cannot or at least have not tried to cross.”
  - [=related to increased tolerance?]
4. More of George’s Highest-Rated Significant Therapy Events

- **Session 9, extremely helpful:** “When (therapist) told me to **confront my mother** [empty-chair work] and tell her how disappointed I was and still am with her. Never did this when she was alive. Should have. It was a relief.”

- **Session 11, extremely helpful:** “Discovery of my **deep-seated anger**. I never knew how much anger could influence how I feel about almost everything I encounter in life.” [=>Tolerance?]
4. More of George’s Highest-Rated Significant Therapy Events

- **Session 16, greatly helpful:** “I found out that before I tackle a problem, I stop breathing. **Upon facing the problem of crossing a bridge I made an effort to breathe clear across the bridge and it worked.**”
  - [=> Bridge crossing]
4. More of George’s Highest-Rated Significant Therapy Events

Conclusion: George’s significant events, as described on the HAT form, are in the clinically significant range (Helpfulness: >7)

- Some are also directly connected to posttherapy changes (Sessions 4, 6, 11, 16)
IV. Critical Reflection

1. **Non-Change Explanations:**
   - Did not improve on any of the quantitative measures from pre- to posttreatment (small increases on IIP, PQ!)
   - Qualitative reported changes not supported by quantitative data
   - Spontaneous remarks: “I’ll talk to that nice young lady any time!”
   - Discrepant data suggest possibility of self-deception by client
George's Ability to Cross Bridges

Bridge Crossing

0: crossed all bridges, only minor distress

2: Unable to cross

Session
3. Critical Reflection

2. Non-therapy explanations:

- In vivo exposure: George reported stable changes in ability to fly and cross bridges only after he flew to Florida and drove across 90 miles of bridges.
- Recent trip: in vivo exposure; Wife’s changed behavior; recurrence of daughter’s cancer
- Research intensive protocol (repeated use of questionnaires, interviews); research staff repeatedly questioned client about changes
Last Scene: The Present
Moment: A Perilous Time
Last Scene: The Present Moment: A Perilous Time

- Continuing pandemic
- War in Ukraine
- Climate crisis
- Rising social inequality
- Increasing political polarisation
- Worsening marginalisation of Gestalt Therapy & HEPs
Coda: Bridging Research and Practice

- Research and practice constitute different worlds.
- But I think that the strategies and developments described here can help transform this situation from a problem to a resource,
- By treating it not as a deficiency but as a creative tension, or a constructive dialectic
- A dance (play?) I have been grateful to have joined in and played a role in
Postscript: Other Useful Methods
Therapy Research Methods That Bridge Research and Practice

1. Systematic qualitative research methods

- Many involve common (generic) descriptive-interpretive methods, e.g.,
  - Empirical phenomenology (Duquesne method)
  - Grounded Theory
  - Interpretative Phenomenological Analysis
  - Consensual Qualitative Research

- A different approach: Discourse analysis/Conversation analysis
Therapy Research Methods That Bridge Research and Practice

**Outcome Monitoring Methods** (Lambert, others):

- Using early outcome to identify and repair problems
- Depends on client initial status: require more positive change for higher initial distress
- Originally developed for Outcome Questionnaire (OQ)
- Generic version developed by Elliott & Breighner using Reliable Change Index and multiple clinical distress bands/cutoffs
  - Extension of clinical significance methods (Jacobson & Truax, 1992)
### Draft Signal Alarm Criteria For Personal Questionnaire

#### Status or Change at Sessions 2 – 4

<table>
<thead>
<tr>
<th>Pretreatment Range:</th>
<th>White</th>
<th>Green</th>
<th>Yellow</th>
<th>Red</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-clinical</td>
<td>&lt;3.25</td>
<td>--</td>
<td>&gt;3.5 &amp; worse by up to 1.5</td>
<td>&gt;3.5 &amp; worse by 1.5+</td>
</tr>
<tr>
<td>Mild</td>
<td>&lt;3.25</td>
<td>Up to .75 worse</td>
<td>.75 up to 1.5 worse</td>
<td>Worse by 1.5+</td>
</tr>
<tr>
<td>Moderate</td>
<td>&lt;3.25</td>
<td>Any better</td>
<td>No change or up to 1.0 worse</td>
<td>Worse by 1.0+</td>
</tr>
<tr>
<td>Severe/Very severe</td>
<td>&lt;3.25</td>
<td>Better by at least .75 (Sessions 5+: better by at least 1.5)</td>
<td>Better by less than .75 (Sessions 5+: no change or better by less than 1.5)</td>
<td>Any worse</td>
</tr>
</tbody>
</table>
Promising Therapy Research

Methods

- New, powerful psychometric methods
  - Rasch analysis/Item Response Theory
  - Traditional psychometric methods are easy to use but ignore much valuable information, including item difficulty levels
  - Quite technical, but can produce simpler, more useful, better understood quantitative measurement instruments
Overview of Practical Uses of Rasch Analysis - 1

1. Determine number and anchoring of scale points.
2. Improve scale internal consistency and efficiency by dropping unnecessary scale points and misfitting items.
3. Identify individual respondents with inconsistent (or overly consistent) patterns of responding.
4. Evaluate range of discrimination within a population that measure allows. (*person separation*)
Overview of Practical Uses of Rasch Analysis - 2

- 5. Evaluate range of discrimination among items that measure allows (*item separation*)
- 6. Evaluate construct validity of measure in relation to hierarchical structure of variable
- 7. Identify measurement gaps in need of additional items
- 8. Identify sampling gaps in the need of further research
- 9. Test and refine theories about sequence, development, rank of construct
10. Evaluate unidimensionality of measure
11. Equate different instruments measuring the same concept