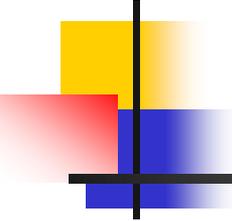




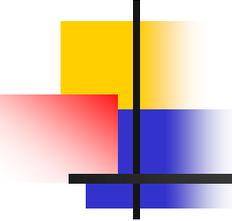
Research & Practice in Gestalt Therapy: Promoting the Dialogue

**Robert Elliott
University of Strathclyde**



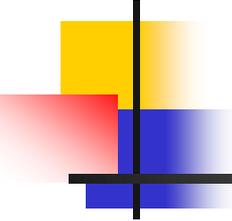
General Presentation

- 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



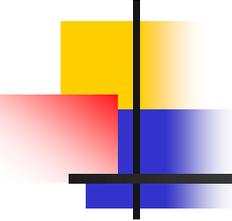
Research-Practice Gap in Psychotherapy

- 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



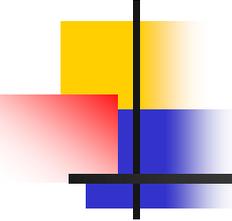
Likely Sources of Research-Practice Gap: *Practice Side*

- Busy lives/Work pressures
- Fear/threat to preferred ways of working
- Complexity of practice/role of context
- Unresolved bad experiences with research during training



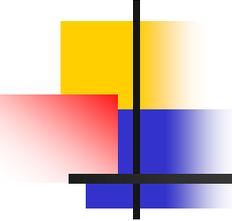
Likely Sources of Research-Practice Gap: *Research Side*

- 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?

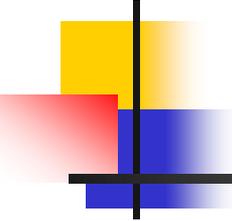
- Morrow-Bradley & Elliott (1986) again:
 - Specific effective therapeutic processes
 - Particular client populations/situations
 - Clients with challenging processes (e.g., personality difficulties)
 - Therapeutic difficulties
 - Case studies
 - Qualitative studies
- = In general, what is specific,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

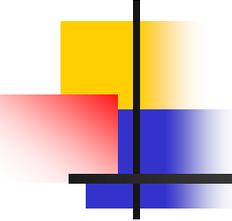
- But...



Research and Practice Can Support Each Other

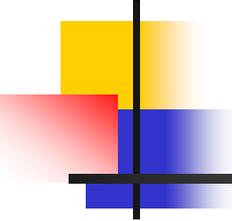
- 1. Practice can **justify research** (introduction sections & grant proposals)
- 2. Practice can be a **source for research** (Stiles: Researchers “consume practice” as a source of inspiration by operationalizing and testing ideas that emerge from practice)
- 3. Research can **justify practice** (example: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

Principles for Practice-based Research - 1

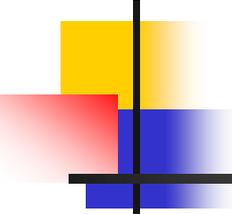


- (1) Make research relevant to actual practice of therapy
- (2) Use methods that support therapy rather than interfere with it
- (3) Actively and continuously involve therapists in selection of research questions and methods

Principles for Practice-based Research - 2

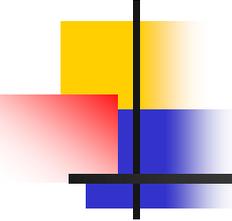


- (4) Include inexpensive and easy-to-use instruments of key elements
 - E.g., Therapeutic alliance, client problem severity
- (5) Encourage variety of research methods
 - Qualitative & quantitative; group & single-case
- (6) Create research networks of training sites using similar, pan-theoretical instruments



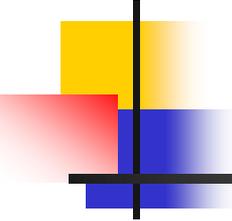
A List of Research Methods that Can Bridge Research & Practice

- 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

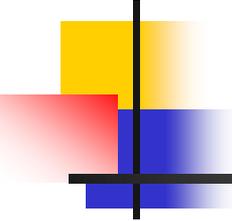
- (1) 1970's PhD research: the painful gap:
 - I love research/the joy of knowing/learning all the ways I can find to know
 - But: Sometimes this feels so far away from my lived experience of struggling to become a half-decent therapist

Scenes from a Therapist- Researcher Career: 2

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

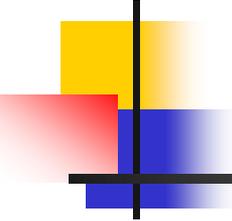


- Interpersonal Process Recall (IPR)
- Record sessions & play them back for client and/or therapist soon after session
 - Actual process
 - Inner experience of clients & therapists
- Hundreds of hours interviewing clients and therapists about their experiences in sessions
- => Made me who I am as a therapist



Scenes from a Therapist- Researcher Career: 3

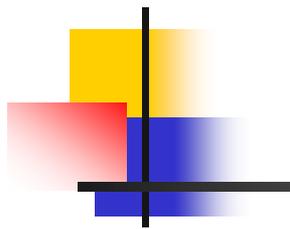
- 1976: While carrying out my PhD research study on clients' experiences of therapist response modes,
- I accidentally came upon the following bit of therapy...
- [Play IPR45 clip]



IPR45



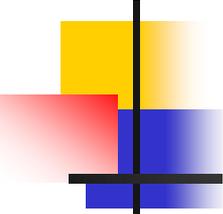
“That in your hands” Episode²



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

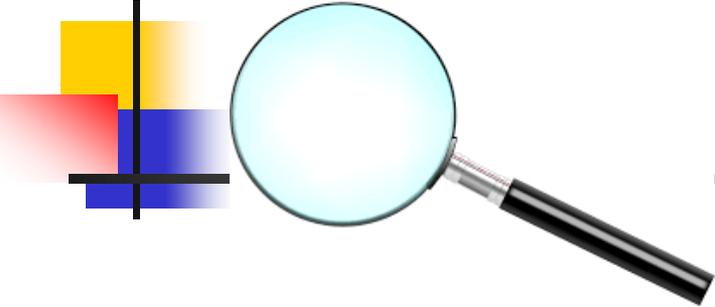


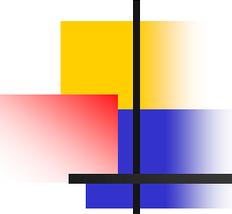
tooth, but that it was actually *beautiful* restoration, it must have given me a lot of confidence that, OK, not only did I not ruin it, but, boy, I really fixed it up. (T:mm) I wonder (1.0).

T2: Yeah, °gee° (1.0).

C3: I *know* that almo—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 s—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(he)m to (h) e(h)ven bo(he)ther him. He—see, it was part of the learning experience—and I kept saying, “I don't do that and I *sti(h)ll* feel horrible—Why?” (1.0) And I think that was it (he) (.5).

Significant Events Psychotherapy Research Paradigm

- 
- 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)

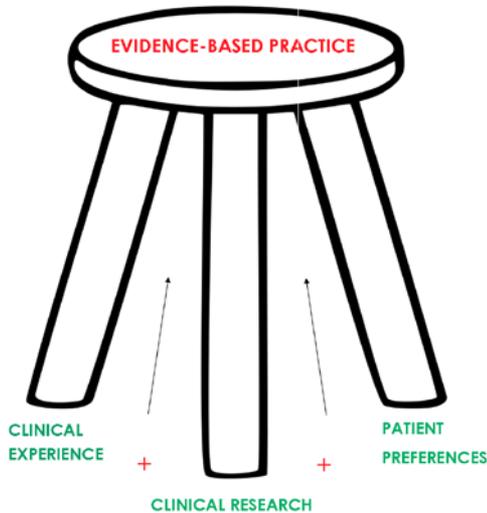
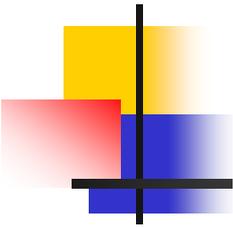


Scene 5: The Black Hole of Process Research

- 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...





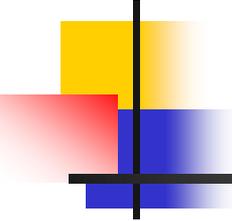
The Evidence-Based Practice Movement

- 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

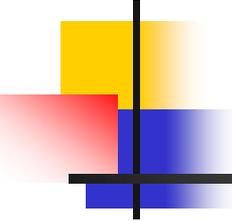


Scene 6: The Politics of Evidence: Humanistic-Experiential Psychotherapy (HEP) Meta-Analysis Project

- 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



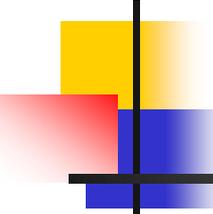
**“Here’s a list of 100,000
warehouses full of data. I’d like
you to condense them down to
one meaningful warehouse.”**



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

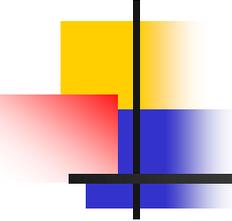
Scene 7 (Montage): The HEP Meta-Analysis Project



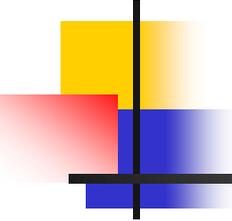
Authors	Year	N of studies
1. Greenberg, Elliott & Lietaer (Bergin & Garfield, <i>Handbook of Psychotherapy & Behavior Change</i> , 4 th ed.)	1994	37
2. Elliott	1996	63
3. Elliott	2002	86
4. Elliott, Greenberg & Lietaer (in <i>Handbook</i> , 5 th ed.)	2004	112
5. Elliott & Freire (Published as Elliott et al in <i>Handbook</i> , 6 th ed.)	2013 (2008 sample)	191 (82 new studies; 67 studies since 2000)
6. Elliott, Sharbanee, Timulak & Watson (in <i>Handbook</i> , 7 th ed.)	2021	+91 new studies from 2009-2018

Meta-analyses of Humanistic-Experiential Psychotherapy Outcome Research

	1947-2008 Meta-analysis			2009-2018 Meta-analysis		
	K Studies	N Clients	M (95% CI)	K Studies	N Clients	M (95% CI)
Pre-Post effect sizes (ES) in HEP samples						
Overall (combined follow-up periods):						
<i>Primary Outcomes (PO)</i>	--	--	--	94	7558	.86 (.74, .97)
<i>All Outcomes (All)</i>	199	14,032	.93 (.88, 1.04)	94	7376	.73 (.62, .83)
<i>By follow-up time period:</i>						
Post (0 – 1 mo post):	181	13,109	.95 (.86, 1.04)	91	6842	.86 (.75, .98)
Early follow-up (2–11 mos.)	77	2125	1.05 (.90, 1.20)	41	2161	.88 (.67, 1.10)
Late follow-up (12+ mos.)	52	2611	1.11 (.93, 1.29)	15	599	.92 (.52, 1.31)
<i>By type of HEP (combined follow-up periods)</i>						
Supportive-Nondirective	32	704	.80 (.63, .97)	30	1564	.73 (.55, .92)
Person-Centered	76	10,450	.95 (.83, 1.04)	18	1258	.98 (.66, 1.29)
Emotion-Focused	34	1138	1.21 (1.04, 1.37)	18	464	1.31 (1.05, 1.58)
Gestalt/Psychodrama				17	723	.78 (.57, .98)
Other HEPs	53^a	1605	.89 (.69, 1.10)	11	3521	.53 (.32, .73)



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)

Study	Effect Size	Description
Beutler 1991	1.424	Focused Expressive
Beutler 1984	.926	Gestalt expressive experiential
Cross1982	1.203	Insight tx based on TA & gestalt principles Primal gestalt tech used
Dahl 1983	1.065	Insight tx based on TA & gestalt principles Primal gestalt tech used
Felton 1973	.932	Gestalt classroom program
Foulds 1970a	.803	experiential-gestalt growth group
Foulds 1971a	.789	experiential-gestalt growth group
Foulds 1971b	.574	experiential-gestalt growth group
Foulds 1976	.682	Gestalt marathon
Foulds 1977	.703	Gestalt workshop
Greenberg H 1978	.561	Marathon

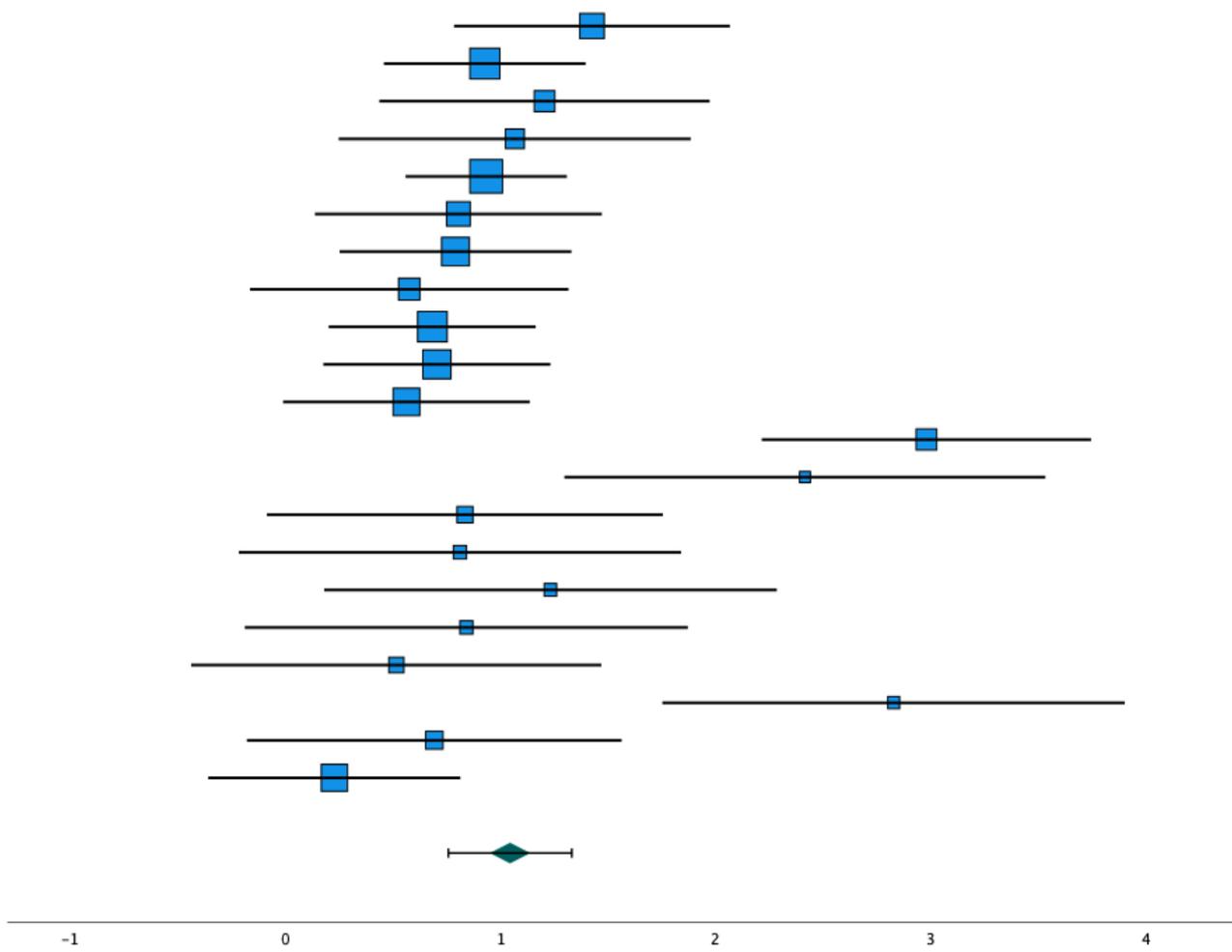
Sample 1 Pre-post effects: 1947-2008 (k = 21), cont

Study	Effect Size	Description
Jessee 1981	2.979	Gestalt couples tx
Johnson W 1976	2.414	Gestalt
Little 1986	.833	Gestalt Family tx
Martinez-FT 2002	.810	Gestalt grp full tx
Martinez-RRP 2002	1.231	Gestalt stimulus role play
Martinez-SRP 2002	.840	Gestalt response role play
Serok 1983	.514	Gestalt grp tx
Serok 1993	2.827	Gestalt grp tx
Tyson 1987 gestalt	.691	Gestalt grp tx
Yalom 1977	.226	Gestalt weekend group
Weighted Mean ES	1.04 (.76,1.33)	Q = 60.7; I ² = 72%

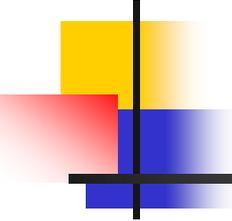
Forest Plot

- Effect size of each study
- ◆ Estimated overall effect size
- | Estimated overall confidence interval
- Confidence interval of effect size

Study	Effect Size	Std. Error	Weight	Weight (%)
Beutler FEP	1.42	0.33	2.44	5.23
Beutler 1984	0.93	0.24	2.77	5.96
Cross1982	1.20	0.39	2.19	4.70
Dahl 1983	1.07	0.42	2.09	4.50
Felton 1973	0.93	0.19	2.94	6.32
Foulds 1970a	0.80	0.34	2.39	5.12
Foulds 1971a	0.79	0.28	2.64	5.66
Foulds 1971b	0.57	0.38	2.24	4.81
Foulds 1976	0.68	0.25	2.75	5.91
Foulds 1977	0.70	0.27	2.66	5.71
Greenberg H 1978 Marathon	0.56	0.29	2.57	5.52
Jessee 1981	2.98	0.39	2.19	4.71
Johnson W 1976	2.41	0.57	1.59	3.42
Little 1986	0.83	0.47	1.91	4.10
Martinez-FT 2002	0.81	0.52	1.73	3.71
Martinez-RRP 2002	1.23	0.54	1.69	3.63
Martinez-SRP 2002	0.84	0.53	1.73	3.70
Serok 1983	0.51	0.49	1.85	3.98
Serok 1993	2.83	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		



Model: Random-effects model



Sample 2 Pre-post effects: 2009 - 2018 (k = 11)

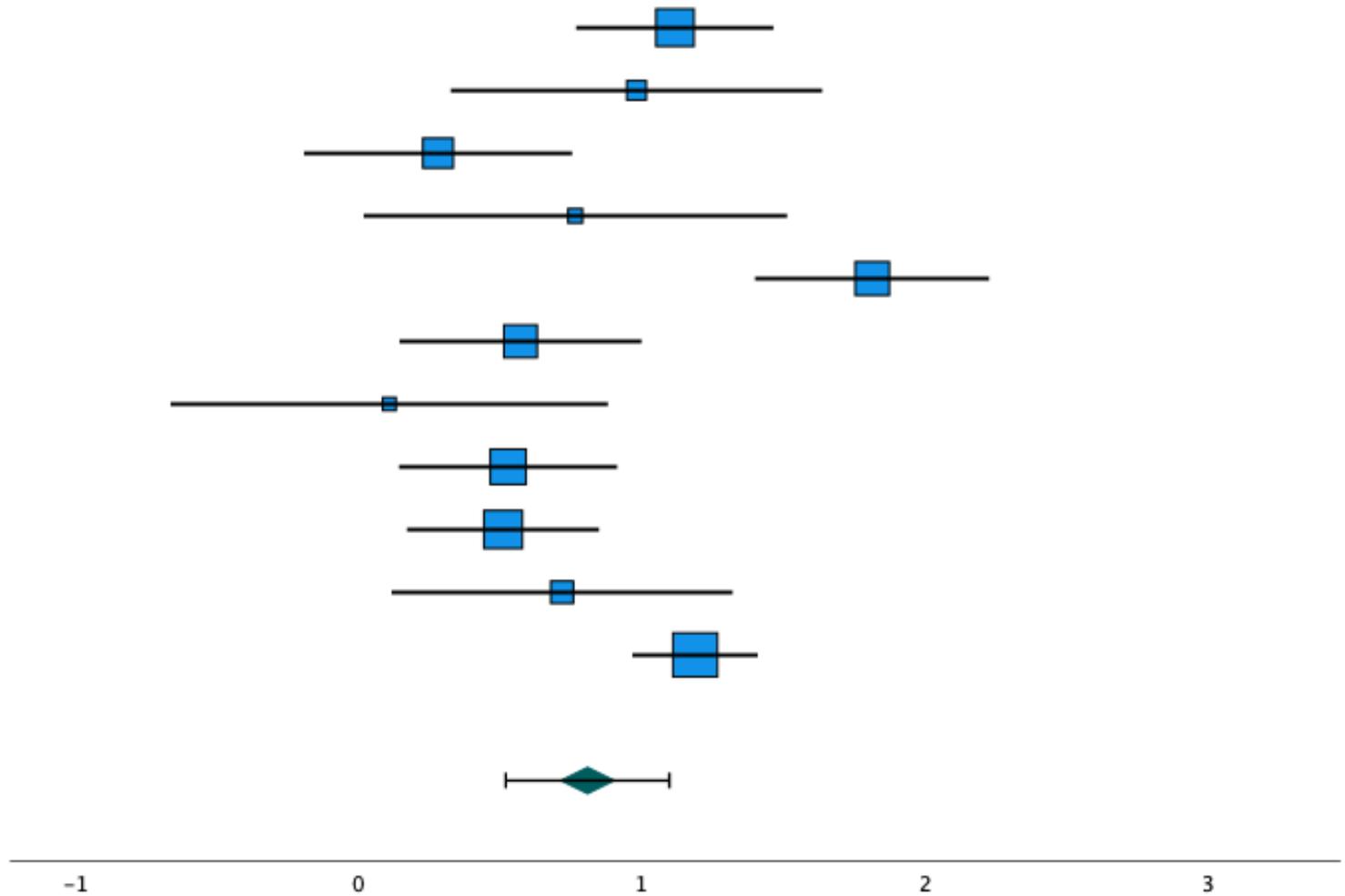
Study	Effect Size	Description
Butollo 2016	1.116	Dialogical exposure therapy
Butollo 2014	.980	Dialogical exposure therapy
Carlson, Tamagawa 2017	.278	Gestalt
Cho 2011	.764	Gestalt group therapy
Compare 2013a&b	1.814	Gestalt
Hagl 2015	.570	Dialogical exposure therapy
Kraljevic 2011	.106	Integrative Gestalt Therapy
Leung 2013	.526	Gestalt-oriented growth workshops
Leung 2017	.508	Gestalt
Schulthess 2016	.717	Gestalt
Stevens 2011	1.188	Gestalt
Weighted Mean ES	.81 (.52, 1.10)	Q = 48.8; I ² = 80%

Forest Plot

- Effect size of each study
- Estimated overall effect size
- Confidence interval of 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



Model: Random-effects model

Meta-analyses of Humanistic-Experiential Psychotherapy Outcome Research

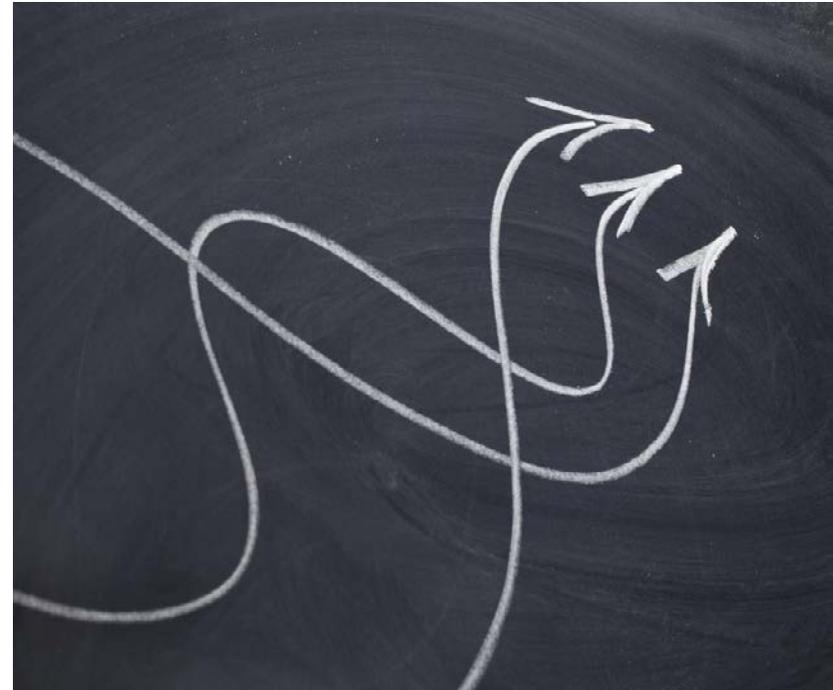
	1947-2008 Meta-analysis			2009-2018 Meta-analysis		
	K Studies	N Clients	M (95% CI)	K Studies	N Clients	M (95% CI)
Controlled ES: HEPs vs. untreated participants						
Controlled effects overall	62	4102	.76 (.64, .88)	21	1519	.88 (.55, 1.20)
Controlled RCTs	31	1146	.76 (.66, .86)	14	848	.98 (.51, 1.44)
HEP pre-post	59	2144	.92 (.83, 1.10)	20	621	.95 (.65, 1.26)
Untreated Control pre-post	53	1958	.15 (.09, .22)	20	648	.09 (-.03, .21)
Comparative ES: HEPs vs. NonHEPs						
Comparative studies overall	135	13485	.00 (-.07, .06)	63	16266	-.08 (-.21, .04)
RCTs only	113	5552	-.03 (-.11, .06)	56	6931	-.07 (-.21, .07)
HEP pre-post	97	5975	.93 (.82, 1.05)	62	5876	.76 (.62, .88)
NonHEP pre-post	122	6985	.98 (.88, 1.09)	62	10262	.82 (.65, 1.00)

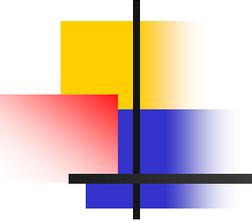
Meta-analyses of Humanistic-Experiential Psychotherapy Outcome Research

	1947-2008 Meta-analysis			2009-2018 Meta-analysis		
	K Studies	N Clients	M (95% CI)	K Studies	N Clients	M (95% CI)
Comparative ES: HEPs vs. Specific NonHEPs						
<i>HEPs vs. CBT</i>						
Overall	77	9041	-.17 (-.25, -.09)	36	13,785	-.26 (-.37, -.15)
RCTs	66	2833	-.17 (-.27, -.07)	32	4641	-.26 (-.36, -.16)
<i>HEP vs. non-CBT</i>						
Overall	58	4444	.17 (.08, .27)	27	2481	.19 (-.04, .43)
RCTs	47	2719	.15 (.03, .28)	24	2290	.24 (-.03, .51)
<i>Different HEPs vs CBT</i>						
PCT vs. CBT	22	6956	-.06 (-.11, -.01)	10	2305	-.31 (-.55, -.08)
Supportive-nondirective vs. CBT	37	1466	-.31 (-.45, -.17)	23	2465	-.31 (-.44, -.18)
Comparative ES: More vs less intensive/ process guiding HEPS						
Overall	9	294	.14 (-.21, .50)	6	640	.18 (-.12, .48)

Summing up the HEP Meta-analysis Project

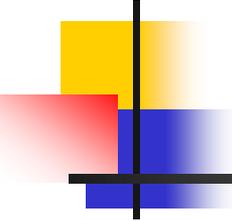
- Three lines of converging evidence:
 - Pre-post effects: How much do clients change over therapy?
 - Answer: A lot
 - Controlled effects: Do clients use therapy to cause themselves to change?
 - Answer: Yes
 - Comparative effects: Are HEPs as effective as CBT?
 - Answer: It's complicated...In general, yes, but with exceptions, eg, PCT < CBT in latest sample





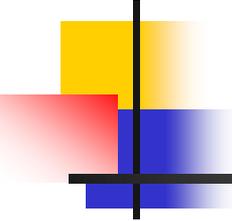
Speculations about the Latest Outcome Findings

- 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?



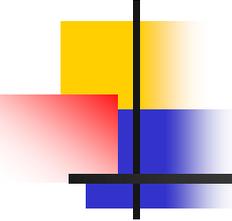
Scenes from a Therapist- Researcher Career

- 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



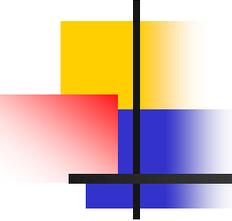
Second Generation Systematic Case Study Research (McLeod, 2010)

- 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



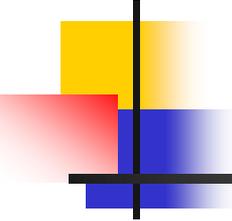
Systematic Case Study Approaches: Central Guiding Stance

- 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



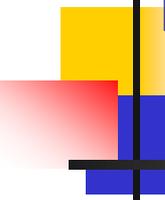
Quality Standards for Systematic Case Studies (McLeod, others)

- 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
- See: Elliott (2001, 2002, 2009 etc)



Three Key Questions in HSCED

(1) Did the client **change** substantially over the course of therapy?

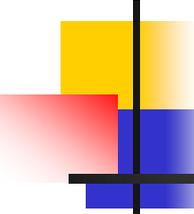
- How much?; How sure are you? (probability: 0 – 100%)
- Also: How and in what ways, in what time course did change occur?

(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**)

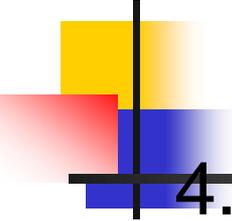
- Moderator variables: Relevant background characteristics of client that affected outcome
- Mediator variables: Processes during therapy period that brought about change



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



HSCED: Additional Principles

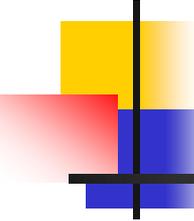
4. **Practicality:** Use easily-implemented, “off-the-shelf measures” (preferably free)

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

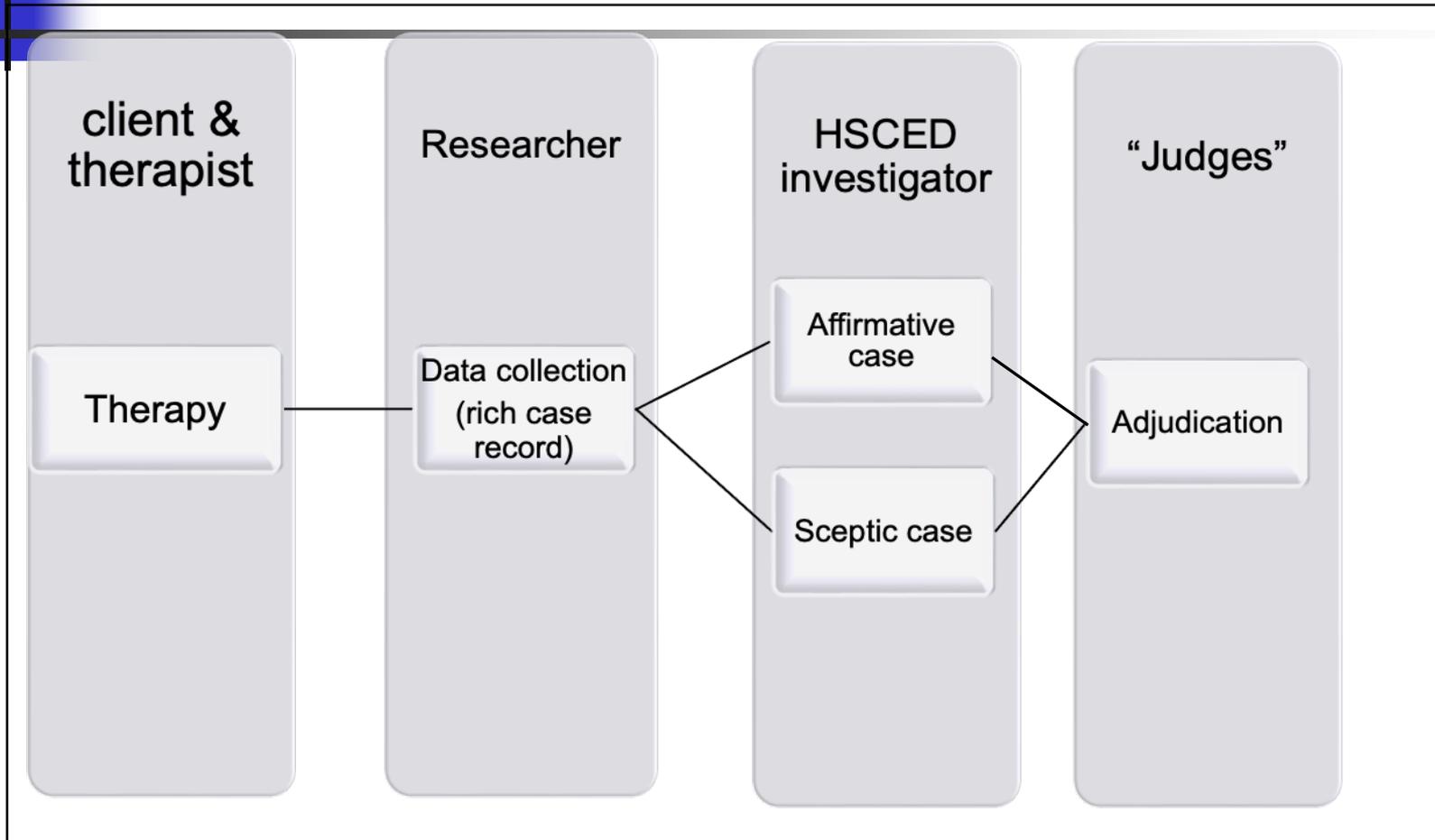
Use broad definition of “cause”; include intentions, offering opportunities

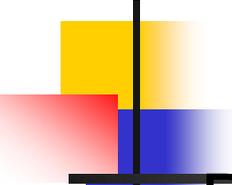


Steps in HSCED's Practical Reasoning Strategy

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

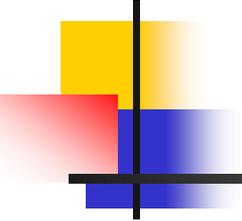
Overview of HSCED process





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

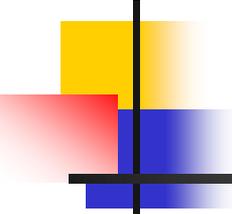
- **Reference:** Elliott, R., Partyka, R., Wagner, J., Alperin, R. & Dobrenski. R., Messer, S.B., Watson, J.C. & Castonguay, L.G. (2009). An Adjudicated Hermeneutic Single-Case Efficacy Design of Experiential Therapy for Panic/Phobia. *Psychotherapy Research*, 19, 543-557
- Go to: <http://strathprints.strath.ac.uk/16829/>

■ **Description of Client**

- 61 year-old European-American male
- Married; some college
- Retired; former security administrator

■ **Psychosocial History**

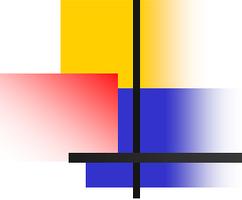
- Emotional and physical abuse
- Suicide attempt as teenager (drove car into quarry)
- Estranged from 2 of 3 children
- Wants to move to SW United States; frustrated that wife won't

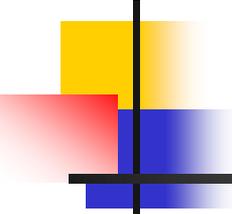


George: Presenting Problems and Diagnosis

- 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”)

Session 1: Presentation of problem

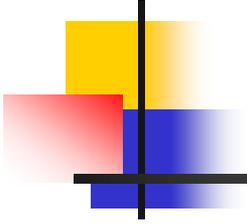


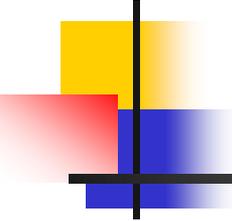


George: Therapy

- 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

	Case-ness Cut-off	<i>RCI Min. ($p < .2$)</i>	Pre-Tx	Post-10	Post-Tx
SCL-90	.93	.51(-/+)	.77	.56	.57
IIP	1.50	.57(-/+)	1.96	1.46	2.27
PQ	3.00	1.00(-/+)	4.33	5.33(-)	4.83

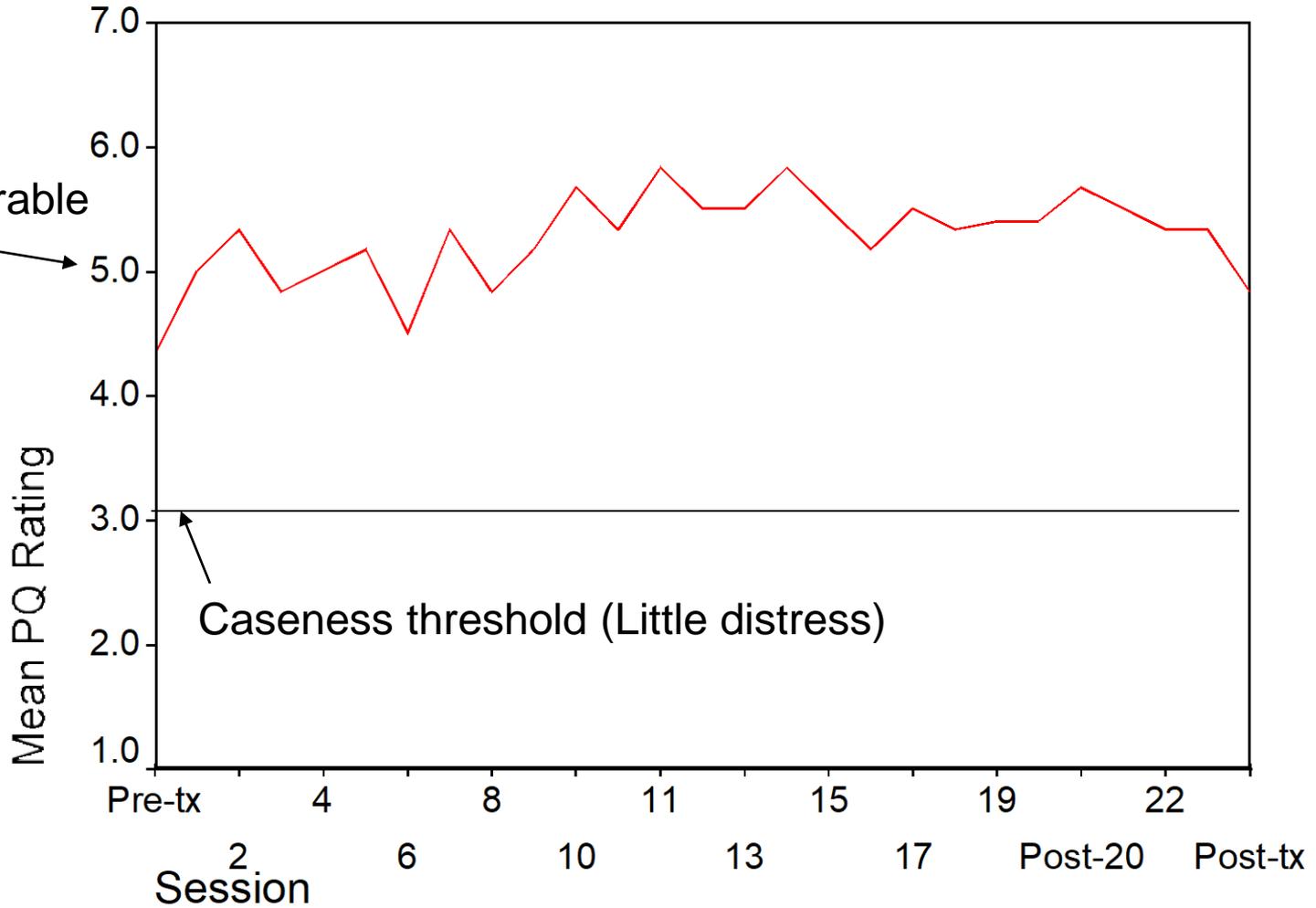
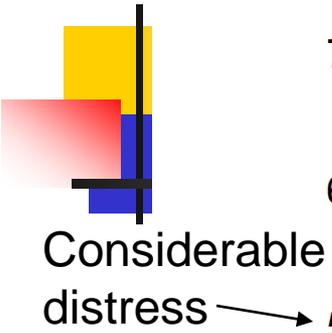
IIP: Inventory of Interpersonal Problems (L. Horowitz)

PQ: Personal Questionnaire (Shapiro, Elliott)

Bold: In clinical range ($>$ caseness)

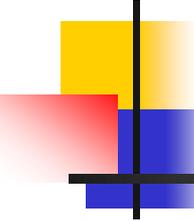
(-/+): Reliable **negative**/**positive** change from pre-therapy

George: Mean PQ Ratings by Session



George's Changes at Post-Tx Interview

	Expectancy	How Likely w/o Tx	How Important
<u>Change:</u>			
Can cross bridges now	Very surprised by	Very unlikely	Extremely important
Better relationship with wife	Very surprised by	Neither likely nor unlikely	Extremely important
More tolerant	Somewhat surprised by	Very unlikely	Moderately important
Less afraid of flying	Very surprised by	Neither likely nor unlikely	Very important



III. Evaluating Therapeutic Influence: Change Process Analysis

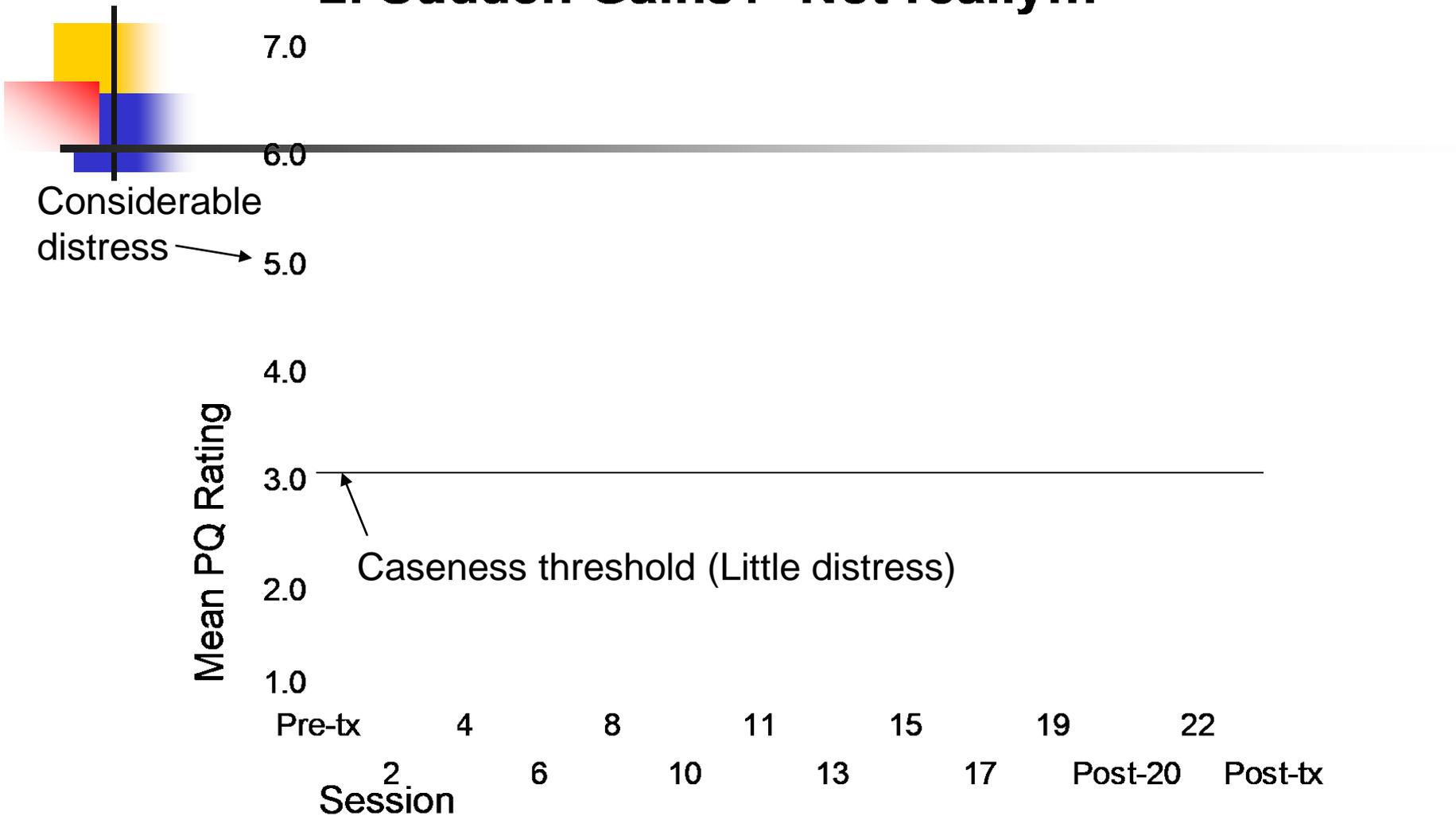
- Looking for 2+ kinds of evidence for connections between what happened in counselling and outcome:
- Types of Evidence:
 - 1. Changes in stable problems: Quantitative/qualitative changes from pre to post, plus information about how long client has had problem
 - 2. Sudden gains within therapy (big 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

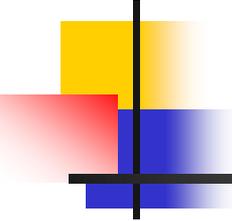
<u>Change:</u>	Corresponding Problem	Duration
Can cross bridges now	Fear of expressway/ heights/ speed [=Bridges]	2 – 5 yrs 5 – 10 yrs 2 – 5 yrs
Better relationship with wife	Problems with relatives/ Abrasive	10+ yrs
More tolerant	Problems with relatives/ Abrasive	10+ yrs
Less afraid of flying	Fear of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

Conclusion: The George showed change on at least some of his stable problems

2. Sudden Gains? Not really...

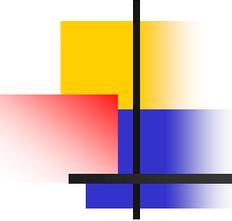


Conclusion: No evidence for therapy bringing about change here.



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**



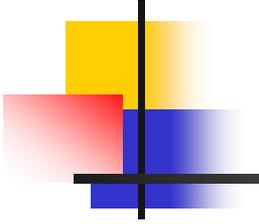
3. Change Interview: George's Post-Therapy Account of What Helped Him

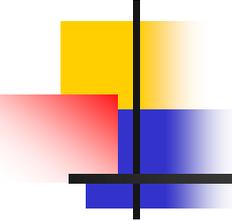
- Conclusion: George described helpful aspects of therapy, attributed some of his changes to therapy (“would not have happened without therapy”).

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?]

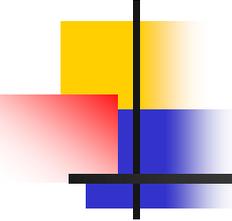
Session 4: Unfolding/Emotion Regulation/ Trauma work





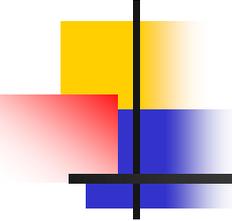
4. George's Highest-Rated Significant Therapy Events

- 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?]



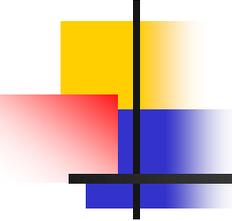
4. More of George's Highest-Rated Significant Therapy Events

- 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?]



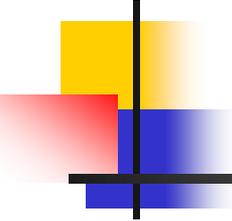
4. More of George's Highest-Rated Significant Therapy Events

- 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

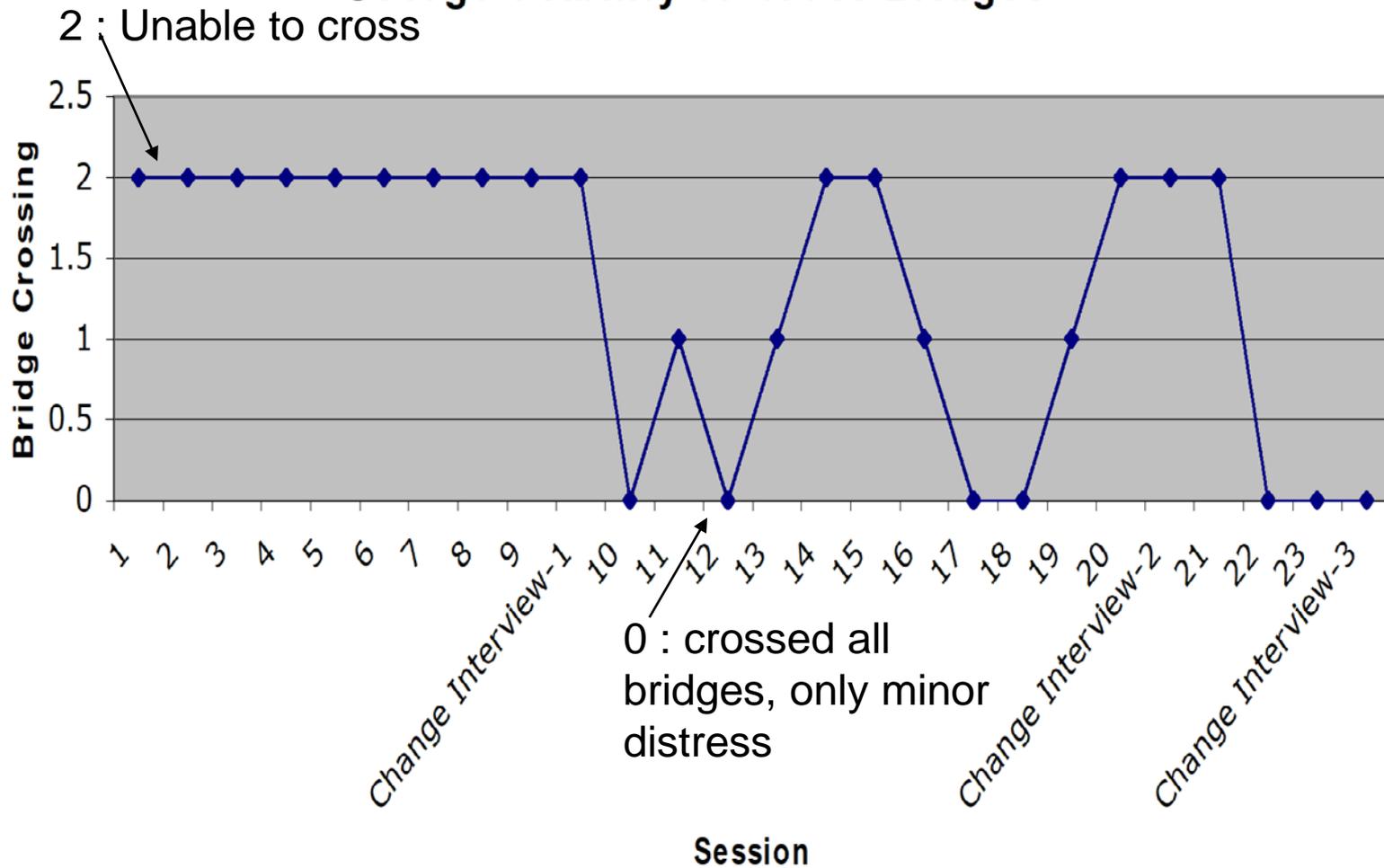
- Conclusion: George's significant events, as described on the HAT form, are in the clinically significant range (Helpfulness: >7)
 - Some are also directly connected to posttherapy changes (Sessions 4, 6, 11, 16)

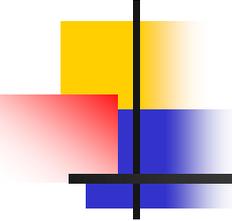


IV. Critical Reflection

- 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

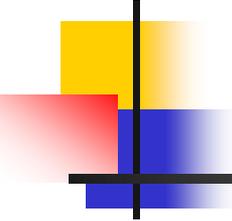
George's Ability to Cross Bridges





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

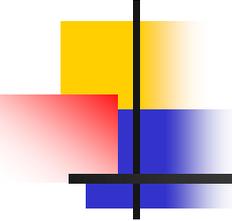


Last Scene: The Present Moment: A Perilous Time

Last Scene: The Present Moment: A Perilous Time

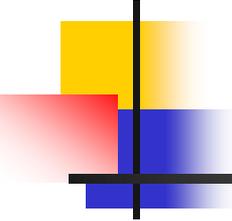
- Continuing pandemic
- War in Ukraine
- Climate crisis
- Rising social inequality
- Increasing political polarisation
- Worsening marginalisation of Gestalt Therapy & HEPs



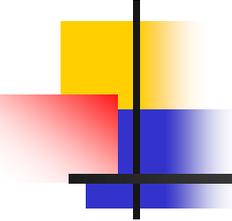


Coda: Bridging Research and Practice

- 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

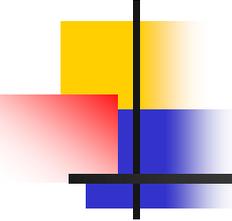


Postscript: Other Useful Methods



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

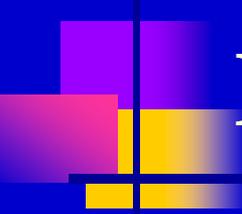


Therapy Research Methods That Bridge Research and Practice

- **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)

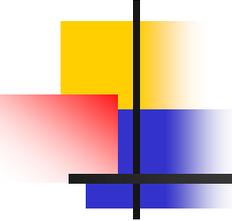
Draft Signal Alarm Criteria For Personal Questionnaire

Pretreatment Range:		Status or Change at Sessions 2 – 4			
		White	Green	Yellow	Red
Non-clinical	1.0 – 2.49	<3.25	--	>3.5 & worse by up to 1.5	>3.5 & worse by 1.5+
Mild	2.5 – 3.99	<3.25	Up to .75 worse	.75 up to 1.5 worse	Worse by 1.5+
Moderate	4.0 – 5.99	<3.25	Any better	No change or up to 1.0 worse	Worse by 1.0+
Severe/ Very severe	6.0 – 7.0	<3.25	Better by at least .75 (Sessions 5+: better by at least 1.5)	Better by less than .75 (Sessions 5+: no change or better by less than 1.5)	Any worse



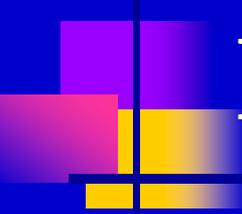
Promising Therapy Research Methods

- **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
 - Bond, T.G., & Fox, C.M. (2001). *Applying the Rasch Model: Fundamental Measurement in the Human Sciences*.
 - Quite technical, but can produce simpler, more useful, better understood quantitative measurement instruments



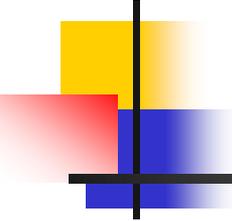
Overview of Practical Uses of Rasch Analysis - 1

- 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



Overview of Practical Uses of Rasch Analysis - 3

- 10. Evaluate unidimensionality of measure
- 11. Equate different instruments measuring the same concept