Practice-Based Research on Psychotherapy

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Research-Practice Gap in Psychotherapy

- Old problem: Morrow-Bradley & Elliott (1986) documented:
  - Practitioners rarely use research to guide practice
  - Therapists learn from clients, supervisors, experience, not research
- General problem of knowledge dissemination: Medicine, engineering, education, social care, law etc.
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

Training Models: Relationship between Science and Practice - 1

1. **Scientist-practitioner**: The original model
   - USA: “Boulder model” (1950)
   - Both research & practice, but separated
   - May be impossible!
   - Source of other models
Training Models - 2

- Current Dominant Models:
  - 2. **Clinical scientist**
    - Academic clinical psychologists
    - Researchers = producers of knowledge
    - Randomized Clinical Trials [RCTs], laboratory research
  - 3. **Evidence-based practitioner**
    - Therapists as consumers of RCT findings

Training Models - 3

- Variations: Integrated models
  - 4. **Applied scientist**
    - UK (M. Shapiro)
    - Integrated model
    - Key method: single case experimental design
  - 5. **Local Clinical scientist**
    - USA professional schools (Treirweiler & Stricker)
    - Integrated model
    - Pluralist methods
Research-Practice Gap in Era of Evidence-Based Mental Health

- Latest in series of top-down solutions:
  - Empirically-validated/supported treatments
  - Evidence-Based Practice (EBP)
  - Practice guidelines (eg UK: NICE)
- Based on:
  - Randomized Clinical Trials research model
  - Therapist-as-research-consumer model

Evidence-Based Mental Health

- Results have been mixed:
  - Guideline development process often politicized and skewed
  - Non-CBT therapists fighting desperate rearguard action in many countries
Likely Sources of Research-Practice Gap: Practice Side

- Busy/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/narrow protocols
  - Psychodynamic, humanistic-experiential, systemic therapies underrepresented
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: (a) findings; (b) concepts; (c) methods

What Research are Therapists Interested in?

- Morrow-Bradley & Elliott (1986):
  - Specific effective therapeutic processes
  - Special client populations/situations
  - Personality disordered clients
  - Therapeutic difficulties
  - Case studies
  - Qualitative studies

  = In general, what is specific and difficult
Research-Practice Integration as a Two-way, Dialectic Process

- Success is more likely if we add a more integrative, bottom-up strategy
- Building on Mental Health Services/Therapy Effectiveness research approaches
- Existing RCT research can make space for grass-roots-based research in real world practice and training settings
- Practice-based Evidence

Principles for Practice-based Research
Principles for Practice-based Research

(1) Make research relevant to actual practice of therapy
   - Use real-world clinical situations, naturalistic client populations
   - Address common or important therapeutic issues, difficulties (e.g., ruptures)

(2) Use methods that support therapy rather than interfere with it
   - Measures that allow clients to self-monitor (e.g., Personal Questionnaire)
   - Qualitative data collection tools that enhance client self-reflection on therapy (e.g., Helpful Aspects of Therapy Form, Change Interview)
Principles for Practice-based Research

(3) Actively and continuously involve therapists in selection of research questions and methods
- Researcher-therapist teams
- Ask therapists what they want to know
- Example, Davis et al (1988) research on therapeutic difficulties

Principles for Practice-based Research

(4) Include inexpensive and easy-to-use instruments of key elements
- E.g., Therapeutic alliance, client problem severity
Principles for Practice-based Research

(5) Encourage variety of research methods
- Qualitative & quantitative
- Client, therapist, observer perspective research tools
- Group & single-case

(6) Create research networks of therapists using similar, pan-theoretical instruments
- Practitioner Research Networks (PRNs)
- Implement in training centres
Promising Approaches to Bridging Research and Practice in Psychotherapy

- Practitioner Research Networks
- Systematic Case Study Research
- Qualitative Change Process Research

I. Practitioner Research Networks

- Online communities & web-based resources
- Signal Alarm Methods
1. Virtual communities/web-based resources

- Foster collaboration, overcome isolation
- Repositories for instruments, research protocols
- Online data collection & test scoring
- Exchange information
- Collect and store data
  - CORE Systems (UK)
  - QIT-online (Belgium)
  - Individualized Patient Progress System (Portugal)

2. Signal Alarm Methods (Lambert):

- Use 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)
### General Signal Alarm Criteria in RCI(p<.05) Units

<table>
<thead>
<tr>
<th>Pretreatment Range</th>
<th>White</th>
<th>Green</th>
<th>Yellow</th>
<th>Red</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nonclinical</strong></td>
<td></td>
<td>&lt;clinical level</td>
<td>.5 to 1 RCI worse &amp; &gt; clinical level</td>
<td>Worse by 1+ RCI &amp; &gt;clinical level</td>
</tr>
<tr>
<td>Mild</td>
<td>+/- .5 RCI around clinical level</td>
<td>Up to .5 RCI worse</td>
<td>.5 to .9 RCI worse</td>
<td>Worse by 1+ RCI</td>
</tr>
<tr>
<td>Moderate</td>
<td>&lt;clinical level</td>
<td>Any better</td>
<td>No change up to 2/3 RCI worse</td>
<td>Worse by 2/3+ RCI</td>
</tr>
<tr>
<td>Severe</td>
<td>&lt;clinical level</td>
<td>Better by at least .5 RCI</td>
<td>No change to less than .5 better</td>
<td>Any worse</td>
</tr>
<tr>
<td>Very severe (Sessions 5+ only)</td>
<td>&lt;clinical level</td>
<td>Better by at least 1 RCI</td>
<td>No change to less than 1 better</td>
<td>Any worse</td>
</tr>
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</table>

### Draft Signal Alarm Criteria For CORE-OM

<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/mild</td>
<td>&lt;1.25</td>
<td>&lt;1.25 &amp; up to .25 worse</td>
<td>&gt;1.25 &amp; worse by .25 up to .5 worse</td>
<td>&gt;1.25 &amp; worse by .5+</td>
</tr>
<tr>
<td>Moderate</td>
<td>1.25 – 2.49</td>
<td>Any better</td>
<td>No change or up to .35 worse</td>
<td>Worse by .35+</td>
</tr>
<tr>
<td>Severe/Very severe</td>
<td>2.5+</td>
<td>Better by at least .25 (Sessions 5+: better by at least .5)</td>
<td>Better by less than .25 (Sessions 5+: no change or better by less than .5)</td>
<td>Any worse</td>
</tr>
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</table>
Example of low-level outcome monitoring with CORE-OM: “Carol”

<table>
<thead>
<tr>
<th>Pre-therapy</th>
<th>After Session 8</th>
<th>After Session 16</th>
</tr>
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<tbody>
<tr>
<td>2.12</td>
<td>2.50</td>
<td>.68</td>
</tr>
</tbody>
</table>

- Moderate distress
- Severe distress
- "Red"
- Mild distress
- "White"

- Carol presented with severe Social Anxiety
- Would have been better to have monitored more frequently, such as on odd-numbered sessions
- Identify exactly when the client went into the red

Carol’s Personal Questionnaire Scores Across Therapy
II. Systematic Case Study Research

- **The New Case Study Movement**
  - John McLeod (2010) summary
- Some brand names:
  - Pragmatic case study (Fishman)
  - Hermeneutic single case efficacy design (Elliott)
  - Adjudicated case study (Bohart)
  - Theory-building case studies (Stiles)
- Suitable for practice settings
### New 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

### Emerging Standards of Good Systematic Case Studies - 1

- 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 forms of measurement
  - E.g., Psychometric measures, process/content ratings, descriptive, interpretive
Emerging Standards of Good Systematic Case Studies - 2

- 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

Example: Adjudicated Hermeneutic Single Case Efficacy Design (aHSCED)

- McLeod, Elliott & Rodgers (2012)
- Carol: Severe social anxiety
- Seen for 16 + 4 sessions of Emotion-Focused Therapy
- Rich Case Record:
  - Qualitative and quantitative data
  - Outcome, change process
- Affirmative & Sceptic position presented in a series of Briefs & Rebuttals
Example: Adjudicated Hermeneutic Single Case Efficacy Design (aHSCED)

- Results:
- 3 Judges ruled:
  - Carol changed
  - EFT was responsible for her changes
  - Attributed change to (=change processes):
    - Therapeutic relationship/therapeutic alliance
    - EFT tasks (especially focusing and chair work)
III. Qualitative Change Process Research

- Change Process Research (CPR)
  - Introduced by Greenberg (1986)
  - Developed to bridge research-practice gap
- The study of the processes by which change occurs in psychotherapy
  - How change occurs
- In particular: The in-therapy processes that bring about client change
- See review by Elliott (2010)
- Focus here on qualitative CPR
  - Greater relevance to practice

Role of Change Process Research

- Necessary complement to
  - Randomized clinical trials (RCT) and
  - Experimental or interpretive single case causal designs
- These focus narrowly on establishing existence of a causal relationship between therapy and client change
  - But do not specify the nature of that relationship
- Also, causal relationships will not be accepted unless there is a plausible explanation or narrative linking cause to effect
- CPR can provide and support these explanations
### Main Genres of Change Process Research Qualitative

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<th>Genre:</th>
<th>For each:</th>
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<tr>
<td>Helpful Factors</td>
<td>Appeal</td>
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<tr>
<td>Discourse/Conversation Analysis</td>
<td>Example</td>
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<tr>
<td>Significant events</td>
<td>Challenges</td>
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<tr>
<td></td>
<td>Recommendations</td>
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1. **Helpful Factors Genre**

- Ask the client
- Post-therapy (Change Interview) or post-session (Helpful Aspects of Therapy Form)
- Variety of qualitative analysis methods:
  - Includes Consensual, Grounded Theory, Narrative etc.
  - Rapidly maturing
1. Helpful Factors Genre - Appeal

- Intuitively obvious
- Fits with mental health consumer movement
- Client as active change agent (Bohart & Tallman, 1999)
- Draws on current popularity of qualitative research in professional psychology training courses

Example: Carol’s Version of What Helped - 1

- Carol: Severe social anxiety
- 16 + 4 sessions of Emotion-Focused Therapy
- Given qualitative Change Interview after 16 sessions
Example: Carol’s Version of What Helped - 2

- I’ll tell you what I think is the most, the greatest thing that I’m feeling: It’s that I’m feeling a sense of belonging ... Just this sense of general belonging. Because I have, no matter where I’ve been, I have never felt part of it. No matter what.

Example: Carol’s Version of What Helped - 3

- The chair work, that has made a lot of things kind of clear.

- I think that I’ve kind of learned to be honest. And I think that’s helped, being able to be honest has helped a lot.
1. **Helpful Factors Genre (Qualitative) - Challenges:**

- Attributional errors; clients may follow cultural scripts
- May not be aware of or able to describe important processes
- Common problems with:
  - Poor interviewing (e.g., leading questions)
  - Superficial data analysis

1. **Helpful Factors Genre (Qualitative) - Recommendations:**

- Apply new qualitative meta-synthesis methods for integrating qualitative research
  - e.g., Timulak, 2007
- Encourage deeper, more critical analysis, better training for qualitative interviewers
- Combine with other methods (e.g., interpretive single case designs)
2. Discourse Analysis/Conversation Analysis

- Micro-analytic Sequential Process approach
- Can be quantitative but theories generally good enough for this
- Appeal:
  - Useful for implicit therapist practice at the moment to moment level
  - Very close to practice: if X, then Y
  - Study causal influence processes directly

Example: Self-soothing dialogues in Emotion-Focused Therapy

- Sutherland, Peräkylä & Elliott (2014)
- Identified concrete conversational practices used by clients and therapists
- Gestalt Two-Chair process: Imagined conversation between a wounded vulnerable aspect of self and a compassionate, caring aspect
- Entry, exit, repair process; pronoun use
- Specific types of self soothing speech acts
2. Discourse Analysis/Conversation Analysis

- Limitations:
  - Distance from therapy outcome
  - Third variable causation may operate
  - Difficult/time-consuming: selection, transcription, measurement, analysis issues

- Recommendations:
  - Combine with other methods (e.g., Task Analysis)

3. Significant Events Methods

- Comprehensive Process Analysis
- Therapeutic Task Analysis
Comprehensive Process Analysis of Significant Therapy Events

- Focused, inductive mixed method approach (Elliott et al., 1994)
- Significant events typically identified by clients and on the basis of successful outcome, but can use rational criteria also
- Use with or without client tape-assisted recall data
- Combines: helpful factors, interpretive qualitative analysis, discourse analysis/conversation analysis, quantitative outcome assessment

Comprehensive Process Analysis of Significant Therapy Events - Appeal:

- Uses pluralistic, converging operations within single study
- Yields rich understandings of significant events
- Close to practice; useful for building clinical micro-theories
- Useful source of analytic tools for other approaches (e.g., Stiles’ Assimilation Model)
- Flexibility: can be used to study a wide variety of therapies and types of events
Example: Carol, Session 8

- **Helpful Aspects of Therapy (HAT) Form:**
  - *Most helpful:* Doing chair work with “God”
  - *Why helpful:* I have been struggling with my “loss of connection” to God* for several months now and during this “communication” I remembered that there’s someone who cares for me and loves me!
  - *Helpfulness rating:* 9 (extremely)

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Example: Carol, Session 8

- **Comprehensive Process Analysis (CPA) of this significantly helpful event would:**
  - **Process:** Analyze what client and therapist did that was so helpful:
    - Therapist encourages client to speak as if she were God and offer validation and support
    - Client actively & creatively engages: “You're my wee lassie and you always will be.”
Example: Carol, Session 8

- Comprehensive Process Analysis:
- Context: Analyze what client and therapist brought to this event that made it so helpful, eg:
  - Client history: religious conversion experience 15 years earlier, from which she had drifted away
  - Therapist: Openness to experimentation, religious content in therapy

Comprehensive Process Analysis of Significant Therapy Events

- **Challenges:**
  - Time-consuming/complexity/technical difficulty (requires mastery of range of methods)
  - Under-utilized

- **Recommendations:**
  - Advocate small-n use for student research projects in professional training programs, as alternative to qualitative interview research
  - Should be more widely used to construct rational models of good practice
Task Analysis of Key Therapeutic Processes/Events

- Focused, rational-empirical mixed method research strategy (Rice & Greenberg, 1984; Greenberg, 2007)
- Collect examples of successful client resolution of a particular kind of therapeutic work (=“task”)
- => Develop, refine & test process models of particular tasks
- Basis of Emotion-Focused Therapy
- Combines: qualitative discourse analysis; quantitative process, research-outcome; helpful factors

Task Analysis: Appeal

- Useful for explicating therapist implicit knowledge
- Close to practice; useful for building clinical micro-theories
- Defines program of research across studies
- Can relate process to outcome
- Uses pluralistic, converging operations
Example of Task Analysis for Compassionate Self-soothing (adapted from Goldman & Fox, 2010)

1. Marker: Anguish combined with Familiar Despair

2. Try to access Compassionate Other

2. Express anguish/unmet need in Experiencer

3. Existential Confrontation

3. Protest

4. Invoking & Expressing Wants and Needs

4. Offer warm, Empathic Understanding & Support

5. Bodily Felt Relief & Empowerment

6. Full Resolution: Experience of Being Soothed, Meaning Creation, Integration

4. Task Analysis - Challenges:

- Complexity; not suited to one-shot investigations
- Based on a specific model of therapy as task-focused/client as active change agent
- Micro-analytic element is difficult/time-consuming
- Under-utilized
4. Task Analysis - Recommendations:

- Should be more widely used to construct rational models of good practice
- Initial therapist qualitative interview phase under-utilized & should appeal to qualitative researchers as an initial step
Conclusions

- Research and practice constitute different worlds.
- The strategies and developments described here can help transform this situation from a problem to a resource,
- Creative tension, or a constructive dialectic

- Tomorrow, in my workshop, I will describe some of the specific research tools I’ve mentioned

Conclusions

- Working close to practice
  - Often studying my own practice
- Combining qualitative and quantitative ways of knowing
- Paying attention to client experiences of significant change
- While also looking closely at what client and therapist do from moment to moment
- => All this, over time, has made me a much better therapist
Thank you for your attention!

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