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# Doing Research on the Effectiveness of Psychotherapy and Psychotherapy Training: A person-centered/experiential perspective

**Forschung zur Effektivität von Psychotherapie und Psychotherapietraining:  
Eine Personzentrierte/Experienzielle Perspektive**  
**Investigar sobre la eficacia de la psicoterapia y de la formación en psicoterapia:  
una perspectiva centrada en la persona /experiential**

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**Abstract.** In this article, we present a framework for selecting instruments for evaluating psychotherapy and psychotherapy training from a person-centered and experiential psychotherapy (PCEP) perspective. The protocol is divided into eight therapy measurement domains, consisting of four research themes (therapy outcome, therapy process, client predictors, training outcome) and two levels (general/pan-theoretical concepts vs. treatment specific/PCEP-oriented concepts). This research protocol provides recommendations about what to measure, encouraging collaboration across different training sites, while still allowing flexibility for individual centers. Minimum and systematic case study data collection designs are described: Minimum designs are appropriate for use in private practice settings with one's own clients; systematic case-study designs can be used for student case-presentation requirements or for publication. The framework and research protocols described are part of an emerging international research project involving private and public training centers in several countries.

**Zusammenfassung.** Mit diesem Artikel stellen wir ein Raster vor, mit dessen Hilfe man Instrumente für die Evaluation von Psychotherapie und Psychotherapieausbildung aus der Perspektive Personzentrierter

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und Experienzieller Psychotherapie (PCEP) Perspektive selektionieren kann. Das Protokoll ist in acht Messbereiche für Therapie gegliedert und enthält vier Forschungsthemen (Therapie-Outcome, Therapieprozess, Klientenprädiktoren, Ausbildungs-Outcome) und zwei Ebenen (allgemeine/theorieübergreifende Konzepte versus behandlungsspezifische/PCEP-orientierte Konzepte). Dieses Forschungsprotokoll gibt Empfehlungen dazu, was zu messen ist, ermutigt zur Zusammenarbeit verschiedener Ausbildungszentren und gestattet dennoch Flexibilität für die einzelnen Zentren. Minimale und systematische Designs zur Sammlung von Daten aus Fallstudien werden beschrieben: Minimale Designs sind für die Verwendung im Setting einer privaten Praxis mit den eigenen Klienten geeignet; systematische Fallstudien-Designs können für die Erfordernisse von Falldarstellungen von Studierenden oder für Publikationen verwendet werden. Die beschriebenen Raster und Forschungsprotokolle sind Teil eines internationalen Forschungsprojektes, das in Entwicklung ist, und an dem private und öffentliche Ausbildungszentren verschiedener Länder beteiligt sind.

**Resumen.** En este artículo, presentamos un marco para la selección de instrumentos para evaluar a la psicoterapia y a la formación en psicoterapia desde una perspectiva de la psicoterapia centrada en la persona y experiencial (PCPE). El protocolo se divide en ocho dominios de medición de la terapia, los cuales consisten en cuatro temas vinculados a la investigación (resultado de la terapia, proceso de la terapia, elementos predictivos de los consultantes, resultado de la formación) y dos niveles (conceptos generales/panteóricos vs. conceptos orientados a la PCEP/de tratamiento específico). Este protocolo de investigación provee recomendaciones sobre qué medir, alentando la colaboración entre los distintos sitios que ofrecen formación, al mismo tiempo que permitiendo flexibilidad para los sitios individuales. Se describen diseños de compilación de datos, mínimos y de estudios de caso sistemáticos: los diseños mínimos resultan apropiados para ser usados por terapeutas con sus propios consultantes en contextos de práctica privada; los diseños de estudios de caso sistemáticos pueden ser usados para responder a los requisitos de presentaciones de estudios de caso o para publicaciones. El marco y los protocolos de investigación descriptos son parte de un emergente proyecto de investigación internacional que involucra a centros de formación públicos en varios países.

**Key Words:** Research, training, person-centered therapy, experiential therapy

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Our purpose here is to encourage practice-based research on person-centered and experiential psychotherapies and to provide some guidance for doing so. Such research can have political, scientific, practical, and ethical goals: to maintain and further our place in the health care provision field; to learn more about the effects and change processes in our therapies; and to improve our ability to help our clients. The last mentioned is important for both practical and ethical reasons, since as therapists or counselors we are benefited by improving our knowledge and skills, and are also obligated to do so for the benefit of our clients.

When therapists in our tradition — at least in North America — largely turned away from research in the 1960s, the result was serious harm to our approaches, the consequences of which we continue to live with to the present day (Lietaer, 1990). In Rogers' case, it was understandable that he left academia and research, as he had already made many important contributions in his long career as an academic and researcher (Kirschenbaum, 1979), but unfortunately many others followed his example.

Over the past 15 years, several writers have looked carefully at the existing research literature on our therapies (e.g., Barrett-Lennard, 1998; Bozarth, Zimring & Tausch, 2001;

Greenberg, Elliott & Lietaer, 1994; Elliott, 2002b; Lietaer, 1990), pointing to the strength of the research evidence and often arguing that the key to maintaining and increasing the recognition of person-centered and experiential therapies in the current political–historical moment is for us to carry out research on these therapies using a variety of methods, including both quantitative clinical trials and qualitative or exploratory research. The moment is ripe for this for several reasons. First, accrediting bodies, insurance companies and governments are increasingly calling for accountability in therapy practice and training. Second, exciting developments in research methodology are opening up new possibilities. Third, an international project on the effectiveness of psychotherapy and training has been initiated and can also provide opportunities for members of our tradition to take a leadership role in practice-based research involving collaboration by therapy trainers in several theoretical orientations.

In this article, we will begin by making a case for practice-based psychotherapy research, then we will describe an organizational vehicle for encouraging collaborative practice-based research. This will set the stage for our main focus: a presentation of a research framework and protocols for studying person-centered and experiential psychotherapies. We will conclude with a discussion of recent methodological developments that promise to enhance this research and a list of suggestions for getting involved in therapy research collaborations.

## RESEARCH–PRACTICE GAP IN AN ERA OF EVIDENCE-BASED PRACTICE

The gap between research and the practice of psychotherapy has been discussed for more than 30 years, with empirical documentation going back at least to Morrow-Bradley and Elliott's (1986) survey demonstrating that practicing therapists made very little use of research in their work with clients. Over the past 20 years numerous attempts have been made to link or unify research and practice in psychotherapy. Most of these have been top-down solutions, in which researchers and policy-makers have tried to dictate to therapists. In the United States the best-known of these efforts has been the Empirically Supported Treatments (EST) movement (Chambless et al., 1996). Controversy continues to rage over this initiative, even 10 years later. For views from within the person-centered tradition, see Bohart, O'Hara and Leitner (1998) and Bozarth (2002); for a summary of the main points on each side, see Elliott (1998). Evidence-Based Practice (or Evidence-Based Mental Health) is the term for the larger, international movement towards building therapy practice on scientific evidence (e.g., Levant, 2005; Rowland & Goss, 2000). Other examples of this approach can be found in recent books attempting to integrate scientific evidence on therapy outcome (e.g., Roth & Fonagy, 2004); the empirically supported relationships task force (Norcross, 2002); and most recently, the empirically supported principles task force (Castonguay & Beutler, 2005).

What almost all of these efforts have in common is that they are based on a top-down, therapist-as-research-consumer model, in which committees of scientists sift through up to 50 years of accumulated research evidence in order to come up with recommendations for how to do therapy. The task forces and editorial teams involved in these various efforts most typically do not either include practicing therapists or clients (increasingly known as mental-

health consumers in the USA). The social construction of reality in these cases only serves to maintain the gap between researchers and practitioners, since, from the point of view of front-line practicing therapists, such projects are typically seen as not relevant to the complexities of clinical practice.

Although it is too early to fully judge the impact of these approaches on therapy practice, it seems that one of their major effects so far has been a negative one: discouraging practice and training in person-centered and experiential therapies in places like Germany and the Netherlands. The other important effect has not been on practice but rather on research, fueling an explosion of research on these therapies since 1990 (see Elliott, Greenberg & Lietaer, 2003).

## PRACTICE-BASED THERAPY RESEARCH

In this article, we argue that successful integration of therapy research and practice will be more likely if we consciously try to build a reality where from the first steps a more integrative, bottom-up strategy is used. Perhaps what we need is not so much evidence-based practice as practice-based evidence (Barkham & Mellor-Clark, 2000). A promising development along these lines is the Practice Research Network (PRN) approach, promoted in the USA by Borkovec, Castonguay and colleagues (e.g., Borkovec, Echemendia, Ragusea & Ruiz, 2001), and in the UK by Barkham and Mellor-Clark (2000). Practice Research Networks are collections of practicing therapists who form research collectives to do research on their own cases using a common data-collection protocol. For example, the Pennsylvania Practitioner Research Network pilot study (Borkovec et al., 2001) used the Inventory of Interpersonal Problems (IIP; Horowitz et al., 1988).

Interestingly, the third generation of the Pennsylvania PRN project (Castonguay et al., 2004) is now being carried out in a training site (the psychology training clinic at Pennsylvania State University). This ongoing demonstration project offers a prototype for the subject of this paper — practice-based therapy research in training sites. The rationale for this approach to practice-based therapy research is as follows: First, in spite of 50 years of psychotherapy research, we know relatively little about contemporary applications of person-centered and experiential therapies, especially with specific client populations. Second, being able to use and carry out therapy process and outcome research is an essential aspect of therapist competence. Third, the best way to learn therapy research methods is for students to begin doing research during their basic or specialist therapy training. Fourth, being part of interesting, clinically relevant therapy research from the beginning of one's training as a therapist is the best way to develop positive attitudes about research and the integration of research and practice and to mend the much lamented research–practice gap.

The principles of this approach to therapy research and research–practice integration can be spelled out as follows:

1. *Practical*: Employ inexpensive and easy-to-use instruments that can enhance therapy rather than interfere with it.

2. *Stakeholder-based*: Actively involve therapists (and clients where possible) in the selection of research questions and methods.
3. *Focused*: Instead of trying to be comprehensive, start by measuring key elements of therapy process and outcome (e.g., therapeutic alliance, client-problem severity).
4. *Incremental*: Once the key elements are in place, consider adding measures of other important concepts (e.g., interpersonal problems).
5. *Methodologically pluralist*: Encourage the use of a variety of research methods (qualitative and quantitative; group and single-case).
6. *Collaborative*: Create research networks of training sites using similar, pan-theoretical instruments, in order to make planning more efficient and to create opportunities for data sharing.

The next part of this article is devoted to the presentation of the organizational context and a conceptual framework for guiding such research on person-centered and experiential psychotherapies.

## THE INTERNATIONAL PROJECT ON THE EFFECTIVENESS OF PSYCHOTHERAPY AND PSYCHOTHERAPY TRAINING (IPEPPT)

IPEPPT was formally initiated in June, 2004 by the Italian Coordinamento Nazionale Scuole di Psicoterapia (CNSP; numbering more than 5000 psychotherapists), and by the 21 psychotherapy associations belonging to the Italian Federation of Psychotherapy Associations (FIAP; numbering more than 10,000 psychotherapists). To date, a Scientific Steering Committee has been formed along with an orientation-specific working group for person-centered and experiential psychotherapies. The general goal of this project is to improve psychotherapy and psychotherapy training in a broad range of theoretical approaches, by encouraging systematic research in therapy training institutes and university-based training clinics. The steering committee is led by Robert Elliott, scientific director, and Alberto Zucconi, coordinator; other members are David Orlinsky (USA), Franz Caspar (Switzerland), Louis Castonguay (USA), Glenys Parry (UK) and Bernhard Strauss (Germany). We have just established a general information website (<[www.ipeppt.net](http://www.ipeppt.net)>). The person-centered and experiential psychotherapies working group maintains a demonstration website (<[www.communityzero.com/pcepirg](http://www.communityzero.com/pcepirg)>) and currently includes members from Belgium, the UK, Canada, the USA, Australia, Portugal, Slovakia, Greece and Austria. We have developed a framework for guiding individual and collaborative research; this framework is a major subject of this article.

### Practice-based research component

This project has two primary components: the first component involves facilitating practice-based research on the effectiveness of psychotherapy in universities and training institutes in

Europe, North America and elsewhere. In these settings, randomized clinical trials are generally impractical and tend not to be useful for understanding or improving therapy. Instead, implementing this component requires the development of a research framework for assessing therapy process and outcome that can be used across a range of theoretical orientations, modalities, and client populations. We have proposed the use of a *star* design for this component: a common protocol shared by all orientations (the main body of the star), to serve as a common metric, plus specialized protocols for different therapy approaches (the star rays). The purpose of such a research framework is to inspire, focus and facilitate practice-based therapy research in training sites. At the same time, it is important to develop clearing houses of measures of therapy process, outcome and change processes, suitable for assessing a wide range of therapeutic approaches, and to provide education and dissemination of knowledge about useful, easy-to-use, practice-based therapy research measures and designs to training institutions. Later stages may include the creation of comprehensive shared databases and creating opportunities for collaborative research via data pooling.

### **Training research component**

The second component of the project involves promotion of research evaluating the effectiveness of therapy training in university- and institute-based training programs. Relatively little is known about the effectiveness of therapy training, in part because of technical and logistical difficulties. These difficulties include, among other things, the absence of agreed-upon measures of therapist functioning and the need to measure therapist change longitudinally over several years of training. Nevertheless, it is important to begin systematic evaluation of therapy training outcomes. These evaluation activities should be able to provide both formative and summative functions. That is, they should enable us to improve training by providing feedback about effective and ineffective training processes; and they should also enable us to demonstrate the effectiveness of training programs to accrediting and funding agencies. A multi-orientation star design is also planned for this component, with a common core of key training outcomes, amplified by specialized evaluation protocols for particular therapy approaches or orientations.

### **RESEARCH FRAMEWORK FOR STUDYING PERSON-CENTERED AND EXPERIENTIAL PSYCHOTHERAPIES**

The star design is appealing because it provides a way to balance the common and divergent interests of researchers. This design requires the development of a common research protocol, which in turn depends on agreement among by researchers and therapists representing different theoretical orientations. However, competing vested interests favoring particular instruments have long frustrated attempts to obtain consensus on a core battery (e.g., Strupp, Horowitz & Lambert, 1997). Here, we propose to avoid such controversies by facilitating a different approach: the development of a more generic research framework that focuses on concepts



rather than specific instruments and that seeks to balance comparability and flexibility. This framework allows both specific treatment and training outcome protocols for particular stakeholder groups (e.g., theoretical orientations) and also choice among comparable measurement instruments.

The general framework for selecting instruments for evaluating psychotherapy and psychotherapy training follows two dimensions that organize eight therapy-measurement domains (see Table 1). The first dimension is research theme, consisting of four foci:

- Therapy outcome: how clients change over the course of therapy
- Therapy process: what happens within therapy sessions
- Client/therapist characteristics: important features of clients and therapists that may affect therapy outcome or process
- Training outcome: how therapists change over the course of training

**Table 1:** *Eight Therapy-Measurement Domains with Examples of Key Concepts*

Research Theme	A. General (pan-theoretical)	B. Treatment-Specific (e.g. person-centered/experiential therapy)
I. Therapy outcome	General clinical distress	Self-concept
II. Therapy process	Therapeutic alliance	Client in-session depth of experiential processing
III. Client/therapist background	Demographics	Client independence vs. dependence
IV. Training outcome	Productive vs. unproductive practice pattern	Therapist facilitative conditions

The first three of these are the traditional major domains of therapy research, while the fourth adds training outcome to the mix. The second dimension is the generality of the concepts studied, and corresponds to the star model; it consists of two levels:

- General/pan-theoretical concepts agreed to as important by a broad range of therapists and researchers
- Specific concepts held to be important within a particular theoretical orientation (e.g., person-centered/experiential), client treatment population (e.g., people living with schizophrenia), or national or language group (e.g., Belgium/Flemish-speaking)

The proposed framework is a nested set of priority lists, intended to allow necessary flexibility while at the same time encouraging consistency within and across treatment approaches. This is accomplished by first prioritizing measurement domains, then prioritizing concepts within measurement domains. Once the relevant concepts are identified, then instruments available in a given language or for a particular client population can be examined. In this way, the draft protocol makes recommendations as to what is probably most important to measure, thus encouraging standardization so that data from different sites can be combined or compared, while still allowing flexibility for individual centers.

It is important to note that the priorities given here are meant as examples only; they express our personal opinions and should be seen as tentative. Different research teams, particularly working from different orientations or suborientations and modalities and with different client groups, will have different views on what the priorities should be and will need to develop lists of treatment-specific instruments within each domain.

Table 2 summarizes the current state of the overall research framework, including recommended concepts for each of the research domains. This list focuses on general concepts rather than specific instruments, and offers short definitions or examples for each concept. The list reflects input from various groups, but is still provisional. It currently includes 21 general or pan-theoretical concepts and 15 concepts specific to person-centered or experiential therapies. Obviously, no single study could measure all of these; instead, the list is more like a restaurant menu with multiple courses to choose from, although ideally a sizeable consortium of research and training sites might together manage collectively to measure all the concepts. Thus, the framework itself is programmatic and also points to the need for collaboration.

**Table 2:** *Research Domains and Key Concepts Recommended for Measurement in the Person-Centered/Experiential Psychotherapy (PCEP) Arm of the International Project*

**Domain I-A. General Therapy Outcome:**

- \*1. Quantitative improvement in general severity of problems/symptoms (pre–post differences in symptom frequency or distress on standard instruments)
- +2. Retrospective qualitative view of change (post-therapy report of changes experienced by client)
- +3. Progress on individualized problems/goals (improvement on problems or goals selected by client)
4. Life-functioning improvement (e.g., improvement in interpersonal, relationship, or work problems)
5. Quality of life (e.g., improvement in subjective well-being or life-satisfaction improvement)
6. Cost-effectiveness (e.g., decrease in health-care utilization or burden or illness)

**Domain I-B. PCEP-Specific Therapy Outcome:**

1. Positive mental health (e.g., improved optimism, resilience)



2. Self-concept (e.g., improvement in quantitative self-evaluation or qualitative self-description)
3. Experiential processing (e.g., decreased alexithymia, increased experiencing)
4. Coping strategies (e.g., decreased external/avoidant or increased internal/emotion-based strategies)

**Domain II-A: General Therapy Process:**

- \* 1. Therapeutic alliance (e.g., client or therapist ratings)
- + 2. Client perception of helpful factors or events in therapy (post-session or post-therapy qualitative reports)
3. Therapist responses (response modes or techniques)
4. Client perception of session value (ratings of qualities or effects of session)

**Domain II-B: PCEP Specific Therapy Process:**

1. Therapist facilitative relationship conditions (rated by client, therapist, or observer raters)
2. Theory-specific client post-session reactions (e.g., feeling understood, resolution of therapeutic tasks)
3. Treatment-specific therapist treatment adherence (e.g., observer or therapist ratings of key therapist attitudes, principles, responses, or tasks)

**Domain III-A: General Client/Therapist Pre-therapy Background:**

- \* 1. Client/therapist demographics (e.g., gender, age, education level, ethnicity, household income)
- \* 2. Therapist professional background (e.g., experience, discipline, theoretical orientation)
- \* 3. Client presenting difficulties/problem description/diagnosis (e.g., self-report inventory psychopathology measures)
- + 4. Client psychiatric medications (e.g., medications, including dose, condition treated, when last changed)
5. Client social support (e.g., number and quality of friends, supportive others, religious or other community involvement)
6. Client personality style (e.g., five-factor model)

**Domain III-B: PCEP-Specific Client/Therapist Background:**

1. Client preference/dispreference for person-centered/experiential therapy
2. Client personal resources for making use of offered treatment (e.g., pre-therapy level of experiential processing; client qualitative interview report of personal resources, limitations for using the therapy)

**Domain IV-A: General Training Outcome:**

1. Therapist facilitative interpersonal skills (e.g., pre-post improvement on performance measures of general therapeutic relational skills)

2. Professional functioning (e.g., post-training level of continuing work involvement or professional growth vs. burnout or stagnation)
3. Students' qualitative perceptions of process and effects of training interviews of students through the process of developing therapeutic skill and presence
4. Improvements in client retention rates, outcome (early to late training)
5. General content knowledge (e.g., ethics, general research findings)

**Domain IV-B: PCEP-Specific Training Outcome:**

1. Person-centered facilitative conditions (e.g., improvements on client or observer ratings of warmth, empathy, genuineness)
2. Specific person-centered/experiential therapist skills (improvement in student or supervisor ratings, e.g., of reflection of feelings; therapeutic tasks)
3. Therapist emotional intelligence (e.g., access to own experience, self-soothing)
4. Content knowledge of PCEP (e.g., theory, practice, research)
5. Maturity (e.g., social awareness)
6. Authenticity (e.g., ability to be appropriately transparent with significant others, internal coherence, positive relationship with self)

\* Recommended concept for minimum protocol.

+ Recommended additional concept for systematic case-study protocol.

**Example: severity of client problems**

A complete explication of all 36 concepts, with examples of corresponding quantitative or qualitative instruments, is beyond the scope of this article. Instead, we will offer an example of a single central concept within the General Therapy Outcome research domain: quantitative improvement in general level of client problems/symptoms. Table 3 presents what are probably the four most important client symptom-severity instruments currently being used in English to assess adult clients. These range from the SCL-90-R (Derogatis, Rickels & Rock, 1976), now almost 30 years old, to the just-published Treatment Outcome Package (TOP; Kraus, Seligman & Jordon, 2005). All of these instruments have extensive, strong reliability and validity data and consist of less than 100 items, which means that they take no more than 15 minutes to complete. All have short forms appropriate for more frequent administration (weekly or biweekly).

The SCL-90-R asks clients to rate symptoms on the basis of how distressed they have been; the other three ask clients to rate how often they have experienced a symptom. Most of the instruments ask clients to use 5-point scales for their ratings and to rate symptom levels over the past week. The CORE-OM (Evans et al., 2002) and the TOP (Kraus et al., 2005) are free; the SCL-90-R (Derogatis et al., 1976) and Outcome Questionnaire (Lambert et al., 1996) require either per-form or licensing fees. All of these instruments can be administered and scored by hand, but have optional fee-based online administration and scoring services.

**Table 3:** *Common English-Language Quantitative Client Symptom-Severity Instruments*

Instrument (length)	Reference	Shorter Forms (length)	Scale Basis Points and Time Frame	Cost	Non-English English Translations
Symptom Checklist-90-Revised (SCL-90-R) (90 items)	Derogatis, et al., 1976	Brief Symptom Inventory (53 items)	Distress 5 points Past week	\$2 each (scoring extra)	12+
Outcome Questionnaire (OQ-45) (45 items)	Lambert, et al., 1996	OQ-30 (30 items); OQ-10	Frequency 5 points Past week	One-time licensing fee (e.g., (10 items) \$30 for a student)	German, Dutch, Spanish
Clinical Outcomes Routine Evaluation Outcome Measure (CORE-OM; 34 items)	Evans, et al., 2002	CORE-SF (18 items)	Frequency 5 points Past week	Free	Italian, Slovak, Norwegian
Treatment Outcome Package (TOP) Adult Clinical Scales v4.0 (58 items)	Kraus, et al., 2005	TOP 37 (37 items)	Frequency 6 points Past 2 weeks	Free	Spanish

**Notes.** (a) Scoring services extra for all instruments. (b) Child or adolescent versions currently available for OQ-45, TOP. (c) Signal-alarm methods can be used with OQ-45, CORE, and SCL-90-R (current version of TOP does not include a summary index).

A key issue is the availability of non-English versions of these instruments. This is somewhat difficult to determine, but it is apparent that the SCL-90-R is the most widely translated: Using Google and other sources, we were able to find evidence of translations in German, Italian, Norwegian, Dutch, Spanish, French, Slovak, Czech, Turkish, Arabic, Farsi, and Finnish. The other three instruments are available in at least one non-English language, most commonly German, Dutch or Spanish. Undoubtedly, additional unauthorized or under-development translations exist.

## RESEARCH PROTOCOLS

The research framework can be used to describe three levels of practice-based research design: minimal, maximal, and systematic case study data collection designs. Minimum designs are appropriate for use in private practice settings with one's own clients; domain priorities are most relevant here, since only a small number of things can be measured. While capable of generating interesting scientific data, the primary motivation for carrying out these designs is political: to show a good-faith effort and to provide overall summary data (summative evaluation). On the other hand, maximal designs are appropriate only for well-resourced research centers and include at least one instrument for each key concept in each of the eight measurement domains (e.g., Center for the Study of Experiential Psychotherapy Research Protocol approximates this: <<http://experiential-researchers.org/methodology/csepsumm.html>>). These designs are useful for measure development research and can play a supportive role for the other protocols. Systematic case-study designs provide an intermediate design, appropriate for carrying out a careful study of a single therapy case for a case-presentation requirement or for publication using Pragmatic Case Study (Fishman, 1999) or Hermeneutic Single Case Efficacy Design (Elliott, 2002a) methods. The main reason for carrying out these designs is to understand the change process in therapy and to improve one's work as a therapist. We will focus on Minimum and Systematic Case Study protocols here.

### Recommended minimum protocol

What, in practical, concrete terms, is the least that one could do by way of evaluating one's — or one's students' work — with clients? Such a minimum design could be useful for busy practice or training settings, and it seems to us that the smallest meaningful practice-based research design consists of three components:

#### *Client problem severity*

First, a measure of client problem severity (general therapy outcome), as discussed in the previous section, is a good starting point and is likely to be most widely accepted. Such measures should be given at the first session of therapy, providing a description of the client's initial clinical state and providing a baseline against which to gauge progress in therapy. In addition, the instrument should be repeated at frequent intervals, preferably every week or

two, in order to reduce data loss from clients dropping out of therapy, a perennial problem of practice-based research.

### *Therapeutic alliance*

Second, it would be a good idea to draw from the domain of General Therapy Process. Obviously, researchers have developed many different therapy process instruments over the past 50 years, but most of these are impractical for routine use in practice and training settings, because they are specific to a particular type of therapy, are fairly long (e.g., Therapy Session Report; Orlinsky & Howard, 1986), or require trained raters. Thus, the most obvious choices for measuring general therapy process to measure come down to (a) quantitative measures of the therapeutic alliance; (b) qualitative reports of client-perceived helpful events or factors in therapy; (c) quantitative measures of therapist responses (response modes or techniques); or (d) quantitative assessments of the value of therapy sessions. While each of these concepts has its advocates, the most logical and generally studied kind of general therapy process is the therapeutic alliance (Horvath & Greenberg, 1994). Several different alliance measures have been developed over the past 25 years; those used most frequently today include the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989); the California Psychotherapy Alliance Scale (CALPAS; Gaston & Marmar, 1994), and the Penn Helping Alliance Questionnaire-II (Haq-II; Luborsky et al., 1996). As with measures of client problem severity reviewed earlier, these instruments all have very good reliability and validity, have multiple versions and, as unpublished tests available from their developers, are essentially free. The shortest one is the 12-item version of the Working Alliance Inventory, as revised first from the original 36-item version by Tracy and Kokotovic (1989) and recently revised again using more powerful psychometric methods, by Hatcher and Gillaspay (2006).

### *Client and therapist background information*

The third component of the minimum protocol is basic descriptive information about client and therapist. Such information is important for characterizing the therapies studied and provides an interpretive context for the results obtained. No generally accepted demographic questionnaires exist, but such forms typically provide the following information:

- Gender (client, therapist)
- Age (client, therapist)
- Educational background (client, therapist)
- Ethnicity (client, therapist)
- Occupation (client) / discipline (therapist)
- Experience level (therapist)
- Theoretical orientation (therapist)
- Presenting problems (client)

Most training clinics collect this information from clients during the intake process, so only forms for the desired therapist information need be added to routine procedures.

### The case for the minimum protocol

This minimal recommended research protocol has multiple strengths as a starting place for research on person-centered and experiential psychotherapies. To begin with, it provides a basic audit of therapy outcome, process, and relevant descriptive background information, which can be of use for administrative monitoring purposes. In addition, this information provides a starting point for evaluating the generalizability of the results.

More importantly, there is now evidence that these instruments are appropriate for the study of PCEPs. Certainly there should be little objection to including a measure of therapeutic alliance. Although some might complain that this construct amounts to a superficial repackaging of Rogers' facilitative conditions, the most widely used alliance instrument was developed by an experiential therapist, Greenberg (working with Horvath from earlier theoretical work by Bordin, 1994). The major difference between Rogers' facilitative conditions and the therapeutic alliance concept is that alliance highlights the collaborative aspects of the relationship rather than focusing primarily on the therapist, a development that is certainly compatible with contemporary dialogical views of person-centered therapy (e.g., Schmid, 2002; Barrett-Lennard, 2002; Cooper, 2005).

Furthermore, even though a pathology-oriented measure of client symptom severity would not be a first choice for most of us working within this tradition, there is actually a long history of successful application of using such instruments in the study of these therapies. For example, in a meta-analysis of person-centered/experiential outcome research Elliott (2001) found that 28% of pre-post effects came from client-rated symptom measures like those in Table 3; the mean effect size for these effects was a very respectable .93, considered to be a large effect size (Cohen, 1988) and close to the overall mean for the study. While this figure was not as large as the effects obtained for individualized change measures, improvement ratings, clinician ratings, or relationship measures, it was larger than measures of social adjustment, self-esteem, experiential processing, or personality/health functioning. In other words, person-centered and experiential psychotherapies tend to look *better* on supposedly narrow client-rated symptom measures than they do on broader or more theoretically-relevant measures!

Applying the minimum protocol in a wide variety of PCEP training sites would be an excellent start, but would clearly be limited from the point of view of studying more theoretically relevant types of therapy outcome and process. Thus, sites would be encouraged to add one or several more theoretically interesting instruments. These could be chosen from lists of concepts in Table 2. For example, measures of key PCEP-specific outcome concepts could be added, such as positive mental health, self-concept, experiential processing and coping strategies; or further process concepts could be included, for example, therapist facilitative conditions, client theory-relevant postsession reactions, or therapist treatment adherence ratings. Adding one or two measures of some of these other concepts might add considerable interest and breadth to the minimum protocol.



## Systematic case-study research protocol

A useful compromise between minimum and maximal versions is one that would be appropriate for providing data for a systematic or interpretive case study. Case presentations are a common requirement in psychotherapy training clinics and institutes, where they are typically used to assess students' abilities to think about clients in theory-relevant terms, carry out effective therapeutic interventions, and integrate research into their work as therapists. Such case presentations can now benefit from the recent development of a new generation of systematic or interpretive case study designs. Fishman (1999), Elliott (2002a) and Schneider (1999) have all put forward expanded single-case designs that take a more interpretive approach to examining client change and its causes. In general, these designs aim to: (1) demonstrate that change occurred; (2) examine the evidence for concluding that therapy was responsible for the change; and (3) explore the processes likely to be responsible for change. These methods emphasize the use of a rich case record of comprehensive information on therapy outcome and process (e.g., using multiple perspectives, sources, and types of data), as well as systematic and critical reflection by the researcher.

Thus, with a bit of extra effort, the minimum protocol and traditional therapy case presentations can be converted into systematic case study research, potentially for publication in clinically-oriented or case-research journals, such as this journal or *Pragmatic Case Studies in Psychotherapy* (available at <pcsp.libraries.rutgers.edu/>). For example, in order to carry out a Hermeneutic Single Case Efficacy Design (HSCED; Elliott, 2002a), the therapist must develop a case record of information about a client's therapy. This would include the elements described for the Minimum Protocol, plus additional measures such as a second quantitative outcome measure; a qualitative interview about client change and important therapy processes; a qualitative post-session assessment of helpful aspects of therapy; and detailed process notes and recordings of therapy sessions.

## PROMISING METHODOLOGICAL DEVELOPMENTS TO FACILITATE COLLABORATIVE RESEARCH

Beyond the arguments made at the beginning of this paper for the timeliness and appropriateness of taking on this kind of practice-based collaborative research, recent advances in research methodology can support and enhance this kind of work. These include systematic qualitative research methods; early outcome signal methods; new, powerful psychometric methods; and web-based resources.

### Systematic qualitative methods

One of the most exciting developments in psychotherapy research over the past 20 years has been the emergence of systematic, rigorous approaches to qualitative data collection and analysis (Elliott & Timulak, 2005; McLeod, 2001). These methods include (but are not

limited to) grounded theory (Strauss & Corbin, 1998), empirical phenomenology (Wertz, 2005); Consensual Qualitative Research (Hill, Thompson, Williams, 1997) and discourse analysis (Potter & Wetherell, 1987). These research methods have brought a breath of fresh air to psychotherapy research; systematic qualitative methods offer a useful complement for enriching, enlivening and illuminating quantitative results.

### **New, powerful psychometric methods**

Earlier, we touched on the problem of competing research instruments as an obstacle for research collaboration. By way of illustration, we reviewed four widely used measures of client problem severity. Having so many measures of the same thing has been both a strength and a limitation for the field, in that it provides different options suited to different views of therapy and different measurement preferences. Such diversity, however, also makes it difficult to compare results of studies using different instruments. Fortunately, a recent development in psychometric methods can provide a solution to this problem, in the form of Rasch analysis, developed as an alternative to traditional approaches by Danish mathematician Georg Rasch (1980). This measurement model, a form of Item Response Theory (IRT), provides a framework and a set of useful tools for assessing the reliability, validity and utility of psychological measures. Although it is too technical to be described here, the method makes it possible to equate different measures of the same construct by tying them each to the same underlying latent dimension. What this means for an international project with researchers using different instruments in different languages is that this form of analysis can be used to equate the instruments (Bond & Fox, 2001), thus allowing both diversity and comparability.

### **Early signal methods**

In a series of recent papers, Lambert and colleagues (e.g., Hawkins et al., 2004; Lambert et al., 2002) have found (a) that clients who show a poor response early in therapy (e.g., get worse) generally have poorer eventual outcomes and (b) that providing therapists or clients with feedback about the lack of progress (signal alarms) leads to better outcomes in those at-risk clients. In this approach, based on the client's beginning level of symptom severity and the amount of positive or negative change shown since pretreatment, it is possible to classify (and color-code) clients as nonclinical (white), progressing well (green), showing possible problems (yellow), or off track (red). In these studies, Lambert and colleagues used the Outcome Questionnaire-45, described earlier. However, Breighner and Elliott (2005) have proposed a more general version of Lambert's decision rules that can then be applied to other instruments such as the CORE or the SCL-90-R.

### **Web-based resources**

In addition to the mix of quantitative and qualitative methodological developments we have listed, the internet makes resources available for collaborative practice-based research. For

example, there are now many different web-based data collection and test-scoring resources (e.g., Best & Krueger, 2004) which can be used to facilitate collaborative research across geographically separated training sites. However, more basically, virtual communities can assist working groups of person-centered and experiential therapy trainers and researchers in planning collaborative research via exchange of ideas, working papers, research instruments and so on. To this end we have created a pilot version of such a community at <[www.communityzero.com/pcepipr](http://www.communityzero.com/pcepipr)>, consisting of sections devoted to Assessment Tools (i.e., instruments), Research Protocol, Research Network (links to related sites), Upcoming Events (e.g., conferences and workshops), Discussions (of questions about research methods), Members (list of names and email addresses) and Notice Board (announcements). This site currently hosts a complete set of Dutch-language instruments for carrying out the systematic case-study protocol. For security reasons, this is a closed website, open by invitation (which requires going to the address given and applying for membership).

## DISCUSSION

In this article we have outlined the main features of a large proposed International Project on the Effectiveness of Psychotherapy and Psychotherapy Training (IPEPPT). At the same time, we have touched on a wide variety of research tools, strategies and protocols. In the process, we have noted the political necessity of engaging in therapy research: research as a matter of justifying our existence to authorities. There is no doubt that survival is an important reason for doing research. However, we believe that there is far more to it than that: there is still much to learn about our therapies, even with common research instruments (see Elliott, in press, for a list of research topics in need of further investigation). Putting it another way, we believe that research — especially when motivated by genuine curiosity — goes beyond survival and is in fact a contemporary expression of the growth tendency. Providing quantitative data makes space for questions of deeper understanding and meaning via qualitative and interpretive methods, methods that are also likely to appeal much more to students and practicing psychotherapists.

We conclude with a list of ways that readers can contribute to these efforts:

1. They can provide comments and suggestions on the lists of concepts and instruments presented in this article; and in general contribute to dialogues on how to measure therapy and training outcomes within person-centered and experiential psychotherapies.
2. They can join the Person-Centered and Experiential Psychotherapy International Research Group virtual community and contribute to the discussions and collections of resource materials there.
3. They can begin implementing the minimum protocol design with their own clients and in their own training setting.
4. If they are located in a non-English speaking country, they can help with translations of key research instruments.
5. They can help collect data as part of psychometric research aimed at improving existing

instruments and at equating different instruments for the same constructs.

6. They can take part in more formal collaborations with similarly inclined training centers to generate data for pooling.

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