

**Organization and Research Framework for An International Project on the Effectiveness of Psychotherapy and Psychotherapy Training (IPEPPT)**

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**Abstract.** In this paper, we present the rationale and structure of an emerging International Project on the Effectiveness of Psychotherapy and Psychotherapy Training, as well as a general framework for selecting instruments for evaluating psychotherapy and psychotherapy training across different theoretical orientations, client populations and national/linguistic groups. The framework is divided into eight therapy measurement domains, consisting of four research themes (therapy outcome, therapy process, client predictors, training outcome) and two levels (general/pantheoretical concepts vs. treatment/population/nation-specific concepts). This research framework provides recommendations about what to measure, encouraging collaboration across different training sites, while still allowing flexibility for individual centers. Person-centered/experiential psychotherapy is used as an example of the specific component. Three 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 carrying out rigorous single case research; and maximal designs are appropriate for well-resourced research centers or consortia.

**Keywords:** Psychotherapy training, case study research, international collaborative research

## **Organization and Research Framework for An International Project on the Effectiveness of Psychotherapy and Psychotherapy Training (IPEPPT)**

Our purpose here is to encourage naturalistic, practice-based research on treatments and training experiences carried out in psychotherapy training centers and to provide some guidance for doing so. The oft-lamented gap between psychotherapy research and practice has led to the near disenfranchisement of many forms of therapy, including Person-centered/experiential, psychodynamic and systems approaches, all of which are currently underrepresented on lists of empirically-supported or evidence-based treatments (e.g., Chambless et al., 1996; Roth & Fonagy, 2004). The key to maintaining and increasing the recognition of these 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 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 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 paper, we begin by making a case for practice-based psychotherapy research; then we describe an organizational vehicle for encouraging collaborative practice-based research. This will set the stage for our main focus: a presentation of a practice-based research framework and protocols for studying treatments and training experiences in psychotherapy training centers and institutes in Europe, North America, and elsewhere. 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 Mental Health**

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 to link or unify research & practice in psychotherapy have been made. In most of these solutions 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; Chambless & Hollon, 1998). Controversy continues to rage over this approach, even 10 years after its inception; for a summary of the main points on each side see Elliott (1998). Evidence-Based Mental Health is the term for the larger, international movement towards based therapy practice on scientific evidence (Roth & Fonagy, 2004; Rowland & Goss, 2000). Other examples of this approach can be found in recent books attempting to integrate scientific evidence on therapy outcome (Nathan & Gorman, 2002; Kazdin & Weisz, 2003); the "empirically supported relationships" task force (Norcross, 2002); and most recently, the "empirically-supported principles" task force (Beutler & Castonguay, 2005).

What all these efforts have in common, however, is that they are based on a top-down, therapist-as-research-consumer model, in which committees of scientists sift through 25 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 include either practicing therapists or clients (increasingly known as “mental health consumers” in the USA). From the point of view of front-line practicing therapists, therefore, such projects are typically seen as simply 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 noncognitive-behavioral experiential therapies. The other important effect has not been on practice but rather on research, fueling an explosion of research on excluded 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 a more integrative, bottom-up strategy is used. Perhaps what we need is not so much evidence-based practice as, to quote Barkham and Mellor-Clark (2000), “practice-based evidence.” A promising development along this line 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 two common client outcome measures, COMPASS (Sperry, Brill, Howard & Grissom, 1996) and 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.

The principles of this approach to therapy research and research-practice integration are spelled out in Table 1, and include relying on inexpensive, user-friendly measurement instruments; involving therapists in the selection of research questions; starting by assessing with a small number of key elements of therapy and expanding on these as needed; using both quantitative and qualitative research methods; and collaborating with other training centers to foster larger-scale research. Together, these principles provide a set of practical guidelines for the sort of research we are talking about.

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.

### **Components of the International Project**

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). The person-centered and experiential psychotherapies working group maintains a demonstration website and currently includes members from Belgium, the UK, Canada, the USA, and Australia, Portugal, Slovakia, Greece and Austria. We are now developing a framework for guiding individual and collaborative research; this framework is the 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 American 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 or base, 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, 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 with Examples of Specific Concepts and Treatment Components**

The star design is appealing because it provides a way to balance the common and divergent interests of researchers. This design relies on the development of common protocol, which requires agreement among by researchers and therapists representing different theoretical orientations. However, competing interests favoring particular instruments have long frustrated attempts to obtain consensus “core battery” (e.g., Strupp, Horowitz & Lambert, 1997). Here, we propose to avoid such controversies by taking 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 flexible 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 2). 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

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:

- Generic/pantheoretical 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 3 summarizes the current state of the generic or pantheoretical components of the research framework, including recommended concepts for each of the four generic 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 19 pantheoretical concepts. 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 to collectively measure all the concepts. Thus, the framework itself is programmatic and also points to the need for collaboration.

### **Example of Key Concept: Severity of Client Problems**

A complete explication of all 19 pantheoretical 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 4 presents what are probably the four most important English-language client symptom severity instruments currently used 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 on-line administration and scoring services.

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, we was able to find evidence of translations in German, 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.

### **Example of Treatment-Specific Research Domains**

Table 5 provides examples of 14 concepts specific to person-centered or experiential therapies, organized into four domains parallel to the generic research domains. Thus, it contains lists of outcome, process, client-therapist background and training outcome concepts relevant to studying person-centered and experiential psychotherapies. For example, trainers at a person-centered training internship or training center might want to administer measures of client positive mental health (outcome), client perceptions of the therapist facilitative conditions of warmth, empathy, and genuineness, and client preference for different kinds of therapist responses, including both empathic responses and expert guiding interventions. They might also track their trainees' ability to communicate those same facilitative conditions over the course of their training.

### **Minimum, Maximal, and Systematic Case Study 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, where only a small number of things can be measured. On the other hand, maximal designs are appropriate only for well-resourced research centers or research consortia, 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>). 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 the Pragmatic Case Study (Fishman, 1999) or Hermeneutic Single Case Efficacy Design (Elliott, 2002a).

#### **Recommended Minimum Protocol.**

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

***Client Problem Severity.*** A general 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 in practice-based research.

***Therapeutic Alliance.*** Second, it would be a good idea to use a general therapy process measure. Over the past 50 years, researchers have developed many different therapy process instruments, 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 the kind of general therapy process to measure come down to (a) a quantitative measure of the therapeutic alliance, (b) qualitative reports of client-perceived helpful events or factors in therapy, or (c) 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). These instruments are summarized in Table 6. 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 & Kokotovic (1989) and recently revised again using more powerful psychometric methods, by Hatcher (2004).

***Client and Therapist Background Information.*** The third component of the minimum design is basic descriptive information about the 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 practice-based research, even on less-studied treatments such as psychodynamic, experiential and systemic therapies. To begin with, it provides a basic audit of therapy outcome, process, and relevant descriptive background information, which can be used for administrative monitoring purposes. In addition, this information provides a starting point for evaluating the generalizability of the results.

More importantly, in spite of frequent objections (e.g., Bohart, O’Hara & Leitner, 1998), there is now evidence that these instruments are appropriate for the study of noncognitive-behavior treatments. Certainly there should be little to object about including a measure of the therapeutic alliance, which has roots in both psychodynamic (e.g., Bordin, 1994) and experiential-systemic (Horvath & Greenberg, 1989) traditions.

Furthermore, even though a pathology-oriented measure of client symptom severity would not be a first choice for most researchers and therapists working within the psychodynamic, experiential or systemic traditions, there is solid evidence that these instruments can be used successfully to study of nonbehavioral treatments. For example, in Elliott’s (2001) meta-analysis of person-centered/experiential outcome research, 28% of pre-post effects (101 out of a total of 357) came from client-rated symptom measures such as those in Table 4; 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 tended to look *better* on “narrow” client-rated symptom measures than they did on broader or more theoretically-relevant measures.

### ***Expanded and Maximal Research Protocols***

Applying the minimum protocol in a wide variety of training sites would be an excellent start, but would clearly be limited from the point of view studying a wider range of general concepts, not to mention more theoretically relevant types of therapy outcome and process. Thus, it would be useful for individual training sites to add one or several more general or theoretically interesting instruments. These could be chosen from lists of general concepts in

Table 3 and from an equivalent treatment-specific list, such as the one given in Table 5. For example, qualitative assessment of client views of change over the course of therapy might be added, or a measure of life functioning (e.g., improvement on interpersonal problems). Furthermore, adding a separate training outcome component would provide another dimension to the research, perhaps by doing qualitative interviews with former or advanced trainees or quantitatively assessing their professional functioning using one or both of the new professional functioning scales developed by Orlinsky and Rønnestad (2005). Thus, adding one or two measures of some of these other concepts might add considerable interest and breadth to the minimum protocol.

The *maximal* protocol would include measures of at least one concept in each of the eight domains. This would be a heavy load for clients and therapists to deal with, and so would be appropriate only for research centers, such as the Center for the Study of Experiential Psychotherapy, whose purposes include measure development, and whose clients and therapists come there to work with the understanding that extensive research participation is part of the contract for treatment.

***Consortia Arrangements.*** Alternatively, the maximal protocol could be implemented in a consortium arrangement involving five to 10 training institutes or clinics (possibly within a language community) as follows: All sites could start from the minimum protocol but add two to three further measures, so that collectively across the consortium the entire protocol was covered. Such consortia could be run by a working group responsible for selecting concepts and instruments, setting up and coordinating data collection, and eventually overseeing data pooling and analysis.

### ***Systematic Case Study Research Protocol***

A research protocol intermediate between minimum and maximal versions is one that would be appropriate for providing the basis for a systematic or interpretive case study. Case presentations are a common requirement in psychotherapy training clinics and institutes, where they are often used to assess students' abilities to develop case formulations, 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. Thus, 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, (3) examine alternative explanations for the change, and (4) examine which processes in therapy might have been 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, traditional therapy case presentations can be converted into systematic case study research, potentially for publication in clinically-oriented or case-research journals, such as *Pragmatic Case Studies in Psychotherapy* (available at [pcsp.libraries.rutgers.edu/](http://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 includes background information, as well as data on therapy process and outcome, using multiple sources or measures. This is a generic research

procedure, intended for use across a wide variety of types of therapy and client populations. The following data are typically used with adult outpatients:

(a) **General client/therapist background** information, as noted earlier, is essential for providing interpretive context for the case, as well as a basis for generalizing the conclusions of the case study.

(b) **General quantitative outcome measures**, for example, client symptom distress (e.g., Symptom Checklist-90-R; Derogatis et al., 1976), client life functioning (e.g., Inventory of Interpersonal Problems; Horowitz, Rosenberg, Baer, Ureño, & Villaseñor, 1988), and individualized change measure (e.g., Simplified Personal Questionnaire; Elliott, Mack & Shapiro, 1999). Many of these measures can be given at the beginning and end of therapy, but it is also a good idea to give one of them every session or every other session.

(c) **Qualitative Interview about client change and important therapy processes**. It is also useful to employ a semi-structured interview (e.g., the Change Interview; Elliott, Slatick & Urman, 2001) to complement the quantitative measures. Such an interview can be used to help understand the quantitative data, and can easily provide both general outcome and process information, such as client descriptions of changes experienced over the course of therapy, their attributions for these changes, and helpful and hindering aspects of their therapy. Such interviews typically take 30 - 45 minutes, can be given at the end of therapy (or, better, every 10 sessions), and are best carried out by a third party (although in some cases it may be appropriate for a therapist to carry it out).

(d) **General therapy process: a qualitative postsession assessment of helpful aspects of therapy**. Another very helpful research tool is weekly open-ended questionnaire that asks clients what they found helpful in that particular session (e.g., Helpful Aspects of Therapy [HAT] Form; Llewelyn, 1988). Such questionnaires can be used to pin-point significant therapeutic processes that may be associated with change on the weekly outcome measure or to corroborate change processes referred to in later qualitative interviews.

(e) **Records of therapy sessions**. Finally, detailed therapist process notes and audio or video recordings of therapy sessions are very useful for pinpointing, corroborating, or clarifying issues or contradictions elsewhere in the data.

To this general template, we would recommend the addition of measure of therapeutic alliance, as described under the minimal protocol. For psychotic adults or children, some or all of the client self-reports can be replaced by therapist or observer-based instruments.

### **Promising Methodological Developments to Facilitate Collaborative Research**

Beyond the arguments made at the beginning of this paper for the timeliness and appropriateness of practice-based 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. Some of these have already been alluded to but will be elaborated in the final section of this paper.

#### ***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; 1999; Elliott & Timulak, 2005; McLeod, 2001). These methods include (but are not limited to) grounded theory (Strauss & Corbin, 1998), empirical phenomenology (Wertz, 2005); hermeneutic-interpretive research (Packer & Addison, 1989), interpretative

phenomenological analysis (Smith, Jarman, and Osborn, 1999), 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. Many traditionally-minded therapy researchers have now learned that 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 and three common measures of therapeutic alliance. 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, another 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 in proper detail here, the underlying theory of Rasch analysis is that useful measurement consists of a unidimensional construct arranged in a hierarchical pattern (e.g., more than/less than) along an equal-interval continuum constructed using log transformations of the data odds ratios and probabilistic equations (Bond & Fox, 2001). Then, equating studies can be done, tying different instruments to the same metric (Wright, 1993). 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 have (e.g., Hawkins et al., 2004; Lambert et al., 2002) have shown (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 these studies, Lambert and colleagues used the Outcome Questionnaire-45, described earlier. However, Lambert’s decision rules for identifying clients as “nonclinical” (“white”), “progressing well” (“green”), showing “possible problems” (“yellow”), or “off track” (“red”) can be inferred from the client’s beginning level of symptom severity and the amount of positive or negative change shown since pretreatment; the resulting decision rules can then be applied to other instruments such as the CORE or the SCL-90-R, (Breighner & Elliott, 2005).

### ***Web-based resources***

In addition to the mix of quantitative and qualitative methodological developments we have listed, the internet makes various 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, even prior to this, 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 demonstration version of such a community at [www.communityzero.com/pcepirp](http://www.communityzero.com/pcepirp), intended to facilitate treatment-specific research on person-centered and experiential psychotherapies. This site consists 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). In order to protect members from spammers, this is a closed website, open by invitation only (which requires going to the address given and applying for membership). Currently, virtual communities have also been formed for Psychodrama research (at: [www2.uni-klu.ac.at/claroline/160321/](http://www2.uni-klu.ac.at/claroline/160321/)) and for training research (at: <http://www.communityzero.com/ptrof>). Our plans are for this site eventually to be spun off from its current host so that it can function more independently and be upgraded with features such as on-line data collection and test scoring.

### ***Methodological pluralism***

It should be clear from this that practice-based research lends itself to the use of a variety of research methods, both qualitative and quantitative, group and single case. Quantitative outcome methods is extremely useful for dealing with large amounts of data and for communicating with government and grant-funding agencies. Numbers is a language that administrators and government officials understand (cf. Elliott, 2002b). While quantitative data can be used to help us understand therapy, it needs to be evaluated critically and carefully (Elliott, 2002a). Nevertheless, 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 practitioners of psychotherapy.

### **Conclusion: Opportunities for Research Collaboration**

In this article we have outlined the main features of a large emerging International Project on the Effectiveness of Psychotherapy and Psychotherapy Training (IPEPPT). Moreover, we have described the application of such a project to the investigation of therapy and therapy training using several different research protocols. We conclude with a list of ways that readers can contribute to these efforts:

1. 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 general therapy and training outcomes.
2. Form or join online discussion groups or virtual communities. Those who have a person-centered/experiential or a psychodrama theoretic orientation or are interested in training research, can join one of the existing virtual communities mentioned earlier; otherwise, they can collaborate to create comparable sites in order to contribute to the discussions and collections of resource materials. (For more general information about IPEPPT and how to start a virtual community, go to: [www.communityzero.com/ipeppt](http://www.communityzero.com/ipeppt).)
3. Begin implementing the minimum protocol design with your own clients and in your own training setting.
4. Trainers can begin to convert traditional case presentation training requirements into systematic case study exercises, with a possible eye toward helping students publish these in one of the new case study journals.

5. Those located in a non-English speaking country, can help with translations of key research instruments.
6. Contribute to psychometric research aimed at improving existing instruments and at equating different instruments for same constructs.
7. Take part in more formal collaborations with similarly-inclined training centers to generate data for pooling.

We note that the larger project is by no means restricted to under-studied therapeutic approaches. The methods described are equally applicable to cognitive and behavioral treatments. It is our intention to facilitate a variety of working groups for different theoretical orientations (e.g., psychodrama, systems therapies), client population groups (e.g., people living with schizophrenia, children), and national or language groups (e.g., Flemish-speaking Belgians; French Canadians).

Finally, from our point of view, the research-practice gap is based on a false dichotomy with roots in positivistic and technological models of psychotherapy. These models emphasize therapeutic technique over relationship and observation over lived experience. The result is a fundamental alienation between practice and research. The practice-based research described here does away with this false dichotomy, by integrating research and practice into a single activity. It is our view that our clients can most benefit from a research-practice integration in which psychologists all their sensitivities and abilities to the task of helping their clients.

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**Table 1**  
**Principles of Practice-Based Therapy Research**

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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.
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**Table 2**  
**Eight Therapy Measurement Domains with Examples of Key Concepts**

<b>Research Theme</b>	<b>A. General (Pantheoretical)</b>	<b>B. Treatment Specific (e.g., Person-Centered/ Experiential therapy)</b>
I. Therapy Outcome	General clinical distress	<i>Self-concept</i>
II. Therapy Process	Therapeutic alliance	<i>Client In-session Depth of Experiential Processing</i>
III. Client/Therapist Background	Demographics	<i>Client Independence vs. Dependence</i>
IV. Training Outcome	Productive vs. unproductive practice pattern	<i>Therapist Facilitative Conditions</i>

**Table 3**  
**Generic Research Domains and Recommended Key Concepts**

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

- \*1. Quantitative improvement in general severity of problems/symptoms (pre to 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 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. Client perception of session value (ratings of qualities or effects of session)

**Domain III-A: General Client/Therapist Pretherapy 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 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)

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\*Recommended concept for minimum protocol.

**Table 4**  
**Common English-Language Quantitative Client Symptom Severity Instruments**

<b>Instrument (length)</b>	<b>Reference</b>	<b>Shorter Forms (length)</b>	<b>Scale Basis, Points &amp; Time Frame</b>	<b>Cost</b>	<b>Non-English Translations</b>
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)	10 (incl. Italian)
Clinical Outcomes in 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
Outcome Questionnaire (OQ-45) (45 items)	Lambert et al., 1996	OQ-30 (30 items); OQ-10 (10 items)	Frequency 5 points Past week	One-time licensing fee (e.g., \$30 for a student)	German, Dutch, Spanish
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. (2) 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)

**Table 5****Example of Treatment-specific Research Domains and Recommended Key Concepts: Person-Centered/Experiential Psychotherapy (PCEP)****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-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-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., pretherapy level of experiential processing; client qualitative interview report of personal resources, limitations for using the therapy)

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

1. Person-centered facilitative conditions (e.g., improvements on client or observer ratings)
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 experience, self-soothing)
4. Maturity (e.g., social awareness)
5. Authenticity (e.g., ability to be appropriately transparent with significant others, internal coherence, positive relationship with self)

**Table 6**  
**Common English Language Therapeutic Alliance Instruments**

<b>Instrument (items)</b>	<b>Reference</b>	<b>Scale Basis, Points &amp; Time Frame</b>	<b>Subscales</b>	<b>Informant</b>	<b>Non-English Translations</b>
Working Alliance Inventory (WAI) (36 items; 12 item short form)	Horvath & Greenberg, 1989; Hatcher, 2005 <sup>a</sup>	Frequency 7 points (revised short form: 5 points)	Bond Task agreement Goal agreement	Client Therapist Observer	Dutch Danish French
California Psychotherapy Alliance Scale (CALPAS; 24 items)	Gaston & Marmar, 1994	Agreement-Disagreement 6 points	Patient Working Capacity Patient Commitment Therapist Understanding and Involvement Working Strategy Consensus	Client Therapist	French Portuguese Italian
Penn Helping Alliance Questionnaire-II (Haq-II; 19 items)	Luborsky et al., 1996	Agreement 7 points	--	Client Therapist	German French Norwegian Dutch (earlier version)

<sup>a</sup>Revised 12-item short form