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Psychotherapists Openness to Routine Naturalistic Idiographic Research?

Celia Sales [1, 2, 3] Sonia Goncalves [2, 3], Angela Fragoeiro [2], Sonia Noronha [2], Robert Elliott [4]

[1] Universidade Autónoma de Lisboa, Portugal.
[2] Centro de Investigação e Apoio à Família, Associação Portuguesa de Terapia Familiar e Comunitária, Portugal.
[3] Centro de Investigação e Intervenção Social, Instituto Superior de Ciência do Trabalho e da Empresa.
[4] Department of Psychology, Counselling Unit, University of Strathclyde, Glasgow.

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Abstract

This study presents psychotherapists' perspectives on the use of the Simplified Personal Questionnaire (PQ; Elliott, Mack & Shapiro 1999) and the Helpful Aspects of Therapy form (HAT; Llewelyn 1988) in routine clinical practice, including the advantages and disadvantages for client and therapist; if and how therapists make use of these instruments during the treatment process; their overall perceived usefulness; and therapists' openness to using PQ and HAT routinely in their clinical work. Twenty-five therapists with experience using with the PQ or HAT filled out an internet survey. Results suggest moderate to good perceived usefulness, and a high rate (91%) of openness among therapists for integrating these instruments into their routine clinical work. Advantages and disadvantages described by therapists were content analysed and are discussed, along with the strengths and limitations of the survey method used here.

Key words: Idiographic measures, Change, Therapist experiences, Practice-based research

The current situation in the psychosocial treatments field is characterised by various scientific and governmental bodies calling for psychological treatments to be empirically supported or evidence-based. However, this emphasis on scientific proof continues to raise vigorous debates on the standards and methods used to assess treatment effectiveness (see Elliott 1998 for a review of arguments on the two sides). The so-called "gold standard" method for establishing a cause-effect relation between a treatment and client change (commonly referred to as treatment efficacy) is commonly asserted to be the randomised clinical trial (RCTs) (e.g., Chambless et al. 1996). However, a key critique of RCTs is their limited application to actual clinical practice contexts (treatment effectiveness). RCTs are typically criticized for the narrow range of clients typically accepted into studies, the atypical nature of the therapies studied, the artificial conditions under which therapy is conducted, and so on. These criticisms suggest the need for non-experimental evaluation methodologies (Pinsof & Wynne 2000). In addition, existing lists of "proven" empirically supported treatments have been faulted as misleading, because they ignore well-established research findings that treatment success depends largely on the client, the therapist and their relationship (Norcross 2002), rather than the type of treatment. As proposed by Lambert, Bergin, and Garfield (2004), proof of effective treatment should be based on the measurement of treatment response in actual practice; that is, by conducting naturalistic effectiveness research, rather than choosing the "right" treatment for the "right" disorder. In this context, there is a call for naturalistic non-experimental research that allows establishing the

effectiveness of psychological treatments, and support mental health delivery decisions.

Routine naturalistic idiographic research

In order to address these issues, recent naturalistic research strategies can help inform the development and outcome of patient care in psychological treatments. These form an emerging field in psychotherapy research, referred to variously as patient-based research (Lambert 2001; Lambert, Hansen, & Finch 2001; Lueger et al. 2001; Lutz 2002), quality management (Kordy, Hannöver, & Richard 2001) and practice-based research (Evans et al. 2002, 2003; Margison et al. 2000; Shepherd et al. 2005; Stiles et al. 2003). This field has provided a set of tools for routine outcome measurement in psychotherapy practice, along with convincing demonstrations of the usefulness of such methods for tracking client progress and providing productive feedback to therapists. Two main approaches have been applied in this area. On one hand, quantitative nomothetic approaches, relying on standardised outcome measures; and on the other hand, idiographic approaches (both qualitative and quantitative) aimed at describing and understanding the individual client's issues and personal experiences of treatment.

These two approaches have complementary benefits. Standardised quantitative outcome measures are easier to administer and to analyse, provide efficient feedback on patient progress, and allow the evaluation of mental health care in and across services (Barkham et al. 2001; Lutz et al. 2005). In turn, idiographic methods illuminate the particular client issues and processes involved in each treatment, therefore informing on the specific processes of clinical recovery that occur in psychological interventions (Evans, Hughes, & Houston 2002; Greenberg 1986).

Driven to monitor client progress and feedback therapist over the course and at the end of the treatment, idiographic strategies involve a close collaboration between therapists and researchers and involved a closer integration of research procedures into clinical practice, thus changing therapists´ and clients´ routines. A key question therefore remains, concerning the extent to which therapists will be open to collaborating in these naturalist studies by monitoring their work with clients.

In fact, over the last 50 years, there has been a profound gap between clinicians and psychotherapy researchers (e.g., Morrow-Bradley & Elliott 1984; Sales 2007). Therapists often feel that research is irrelevant for clinical practice, and implies procedures that are inadequate in their routine (e.g. time consuming) or has negative effects on clients (e.g. client measurement "overdose"). Although the research-practice gap is a long-standing problem, the advent of practice-based research has made it a pressing matter, in that therapists are now being asked to add research instruments to their routine practice. In our view, therapists' openness to participate in naturalistic routine studies depends much on their weighing of the relative pros and cons of

participation: What are the costs for the therapist and for the client? What are the gains?

This article thus reports the results of a small study assessing therapists' views concerning two promising instruments for naturalistic idiographic research: The Simplified Personal Questionnaire (PQ) and the Helpful Aspects of Therapy Form (HAT). As previously noted, these instruments are much to clinical practice that standardised instruments, which should make them more appealing to therapists, however, no data on this question was available when we began this study.

Brief Description of the Instruments

The *Helpful Aspects of Therapy* (HAT: Llewelyn 1988) is a post-session open-ended self-report instrument that asks about patient perceptions of key change processes in therapy. Patients are asked to identify and describe in their own words the most helpful event in the session, and to rate how helpful it was. They are also asked about other helpful or hindering events in the session. The HAT generates qualitative data that lends itself to various research uses, including the identification of significant events texts, multiple forms of qualitative data analysis, quantitative content analysis, hermeneutic efficacy studies (Elliott, Clark, & Kemeny 1991; Elliott, James, Reimschuessel, Cislo, & Sacks 1985; Elliott 2002; Elliott, Slatick, & Urman 2001; Llewelyn, Elliott, Shapiro, Firth, Hardy 1988; Sales, Noronha, Fragoeiro, & Ortega Beviá 2004). Initially developed for individual formats of therapy, the HAT has been adapted to family therapy (Sales 2005) and has been used in routine naturalistic idiographic research in Portugal (e.g., Carvalho, Faustino, Nascimento, & Sales 2007) and Spain (e.g., Sales, Fragoeiro, Noronha, Faísca, & Ortega Beviá 2003). Besides the English original version, there is a Spanish version for family therapy, adapted to the psychiatric context (Sales 2005), and a Portuguese version for individual therapeutic formats (Sales, Gonçalves, Silva, Duarte, Sousa, et al. 2007).

The *Simplified Personal Questionnaire* (PQ; Elliott, Mack, & Shapiro 1999) is a target complaint individualized change measure, consisting of roughly 10 problems that a client would like to work on in his or her therapy. The questionnaire is constructed in a semi-structured 45 minutes' interview conducted in order to help the patient to state her main problems. Patients' statements are placed on individual note cards, rank ordered and typed onto a standard form. Patients are then instructed to "rate each of the following problems according to how much it has bothered you during the past seven days, including today", using a 7 points-scale (from 1 = not at all, to 7 = maximum possible). The PQ form is generally administered immediately before each session, providing a session-to-session outcome measure. Over the course of treatment, patients are allowed to change the PQ form, by entering new complaints or deleting previous items if they wish. PQ adaptation to family therapy involves the construction of a PQ per family member (Sales 2005). PQ has been used as an idiographic outcome measure in family therapy in Spain and Portugal (e.g., Carvalho, Faustino, Nascimento, & Sales 2007; Sales, Fragoeiro, Noronha, Faísca, & Ortega

Beviá 2003). A multi-therapeutic format version (i.e., suitable for individual, family or group therapy) has recently been developed in Portugal (Sales, Gonçalves, Silva, Duarte, Sousa, et al. 2007).

In this paper we give voice to the therapists, by eliciting their descriptions and opinions about PQ and HAT integration in routine clinical practice. Specifically, we ask: (1) Have PQ and/or HAT been used in naturalistic research or clinical practice? (2) How do therapists use the information gathered by these instruments? (3) To what extent do they find these instruments useful? (4) What are the benefits and the disadvantages perceived by therapists? (5) What are the benefits and the disadvantages do therapists perceive for clients? (6) To what extent are therapists open to integrating PQ and HAT into their daily clinical work?

Method

Participants

An e-mail message inviting participation was sent to the Society for Psychotherapy Research (SPR) e-mail list, as well as to teams and centres who were known to be using one or the other of the instruments, suggesting a maximum possible sample of roughly 500. A sample of 25 participants was obtained, including 20 women and 5 men, from 3 different countries (Portugal, n = 21, 84%; Spain, n = 3, 4%; USA, n = 1, 4%) responded. Two (8%) of the participants identified themselves as being therapists exclusively, 5 (20%) as therapists and researchers, and 18 (72%) as therapy trainees. Participants' ages ranged from 24 to 55 years (M = 31.76; SD = 8.31). Concerning the clinical experience, 37% (n = 7) of the participants reported between 1 and 5 years of clinical experience, 32% (n = 6) had 1 year or less, 21% (n=4) had more than 15 years, and 11% (n = 2) had between 10 and 15 years of experience.

Criteria of inclusion were previous experience with either of the instruments in clinical context. This experience using these tools differed among participants, as the majority (n=20, 77%) had used PQ less than 20 times, and only three persons (12%) had used it more than 50 times. In relation to HAT, 89% (n=23) had used HAT less then 20 times and only three (12%) reported more than 50 HAT applications.

Procedure and instruments

The questionnaire was comprised two sections (one for each instrument). Each section started with two multiple-choice questions regarding the instrument's context of use, followed by a set of open questions about perceived benefits and disadvantages. It then asked about the overall perceived usefulness for therapist and client, using a 5-point *Likert* scale (from 1 = *not useful* to 5 = *extremely useful*). The section finishes with two multiple-choice questions about therapists´ openness to integrating the instrument in their clinical routine work.

Data were collected through an internet survey, using free web-based software (available in www.makesurvey.net). Three questionnaire versions (English, Portuguese and Spanish) where constructed, with independent access by means of separate links indicated in the message requesting participation. All the data collected by the on-line survey were automatically stored in an Excel spreadsheet.

The analysis of the data had two steps: (1) content analysis of the open questions and (2) descriptive statistics using the statistical software SPSS 14.

Results

The results are presented according to the six research questions:

1. **Have PQ and/or HAT been used in naturalistic research or clinical practice?**

In approximately 60% of the cases, instruments were used both for clinical practice and research purposes. The remaining participants have used them exclusively in their clinical practice (see Table 1).

Table 1 Contexts of PQ and HAT use

		PQ		HAT	
		N	%	N	%
In what context?	Clinical practice only	9	38	10	40
	Both clinical practice & research	15	63	15	60
	Research only	0	0	0	0
	Total reporting	24	100	25	100

2. When do therapists use the information gathered by these instruments?

Therapists used PQ and HAT in different clinical tasks, with a greater incidence of in-session preparation, immediately before sessions (PQ: 92% of respondents; HAT: 84%) and at the end of sessions (PQ: 75%; HAT: 84%). Results are displayed in Table 2.

3. To what extent are these instruments useful?

Table 3 displays results concerning this question. Both instruments are rated as useful for the therapist. Mean usefulness for the therapist is 3.4 for the PQ,

and 4.0 for the HAT. When asked if they felt that using these instruments bring benefits for the client, therapists also rated its usefulness positively (PQ usefulness mean = 3.7; HAT usefulness mean = 3.8).

Table 2 Routine clinical tasks where PQ and HAT are used

		PQ		HAT	
		N	%	N	%
In what specific clinical task?	Admission of new cases	13	54	2	8
	Session preparation/pre-session	22	92	21	84
	Session discussion/post-session	18	75	21	84
	Case supervision	12	50	14	56
	TOTAL	**24**	*	**25**	*

*Note. Totals add to more than 100% because of multiple responses.

Table 3. Therapist Perceptions of PQ and HAT usefulness for therapist and client.

	PQ N AND %					HAT N AND %				
	1 Not usef'l	**2**	**3**	**4**	**5 Extremely usef'l**		**1 Not usef'l**	**2**	**3**	**4**	**5 exte mely usef'l**
Useful for therapist	0	1 4%	7 29%	11 46%	5 21%		0	0	5 23%	12 55%	5 23%
Useful for client	0	4 17%	7 29%	5 21%	8 33%		o	2 8	7 28%	10 40%	6 24%

4. What are the specific perceived benefits for the therapist?

Using an open-ended response format, therapists reported both PQ and HAT as sources of information helpful for therapeutic work (see Table 4). The most common benefits of using the PQ were for session-to-session outcome monitoring over the course of treatment (Frequency – 9; 38% of respondents), enhancing knowledge of client and family specific complaints

(8; 33%), and for clinical decision making on ongoing treatment (5; 21%). For instance, one family therapist reported that the PQ is useful for the therapist in order "*to gather information about each element of the family, of the family complaints, of the relations that the members establish between themselves, of the potential that each one has to enrich the familiar system".* Another therapist felt that PQ offers "*help in evaluating the evolution of the complaints during the treatment".*

As the most frequent advantages of HAT, therapists referred to finding out about client and family feelings and opinions about sessions (8; 33% of respondents), facilitating session-to-session qualitative outcome monitoring (6; 25%), and providing immediate feedback on sessions (4; 17%). One therapist reported different benefits, depending on when the HAT is administered: *"Immediate feedback on your intervention, when administered right after the session; evaluation of the clinical evolution since the last session, when passed before the session; to know how each family member feels during the interventions".*

5. What are the perceived disadvantages for the therapist?

PQ and HAT share the same kind of disadvantages. First, the need for extra time and human resources (PQ: 3; 14% of respondents; HAT: 5; 24%). Specifically about PQ, "*the initial interview, in familiar therapy, implies to have more than one interviewer and space to proceed to the initial interviews; it forces a change in the routine, since it is necessary to have printed the form of each member of the family".* About HAT, is pointed out, *"practical issues: It requires plenty of time for the family to fill the forms; when the participant can't read, it requires someone to help him, which isn't always practical".* A second disadvantage is the therapist being overloaded with an excess of information (PQ: 5; 24%; HAT: 2; 10%). The other disadvantage most frequently pointed out is the risk of an excessive focus on the client/ family's point of view, especially of their complaints (PQ: 10; 48%; HAT: 3; 14%): *"The therapist could, eventually, get too centered in the complaints that were defined in the PQ which can make it difficult to see beyond them. Moreover, he may feel discouraged in face of less positive results".* About HAT: *"To grasp himself too much to the information collected through the HAT, being able to relinquish others' alternatives".*

6. What are benefits do therapists perceive for the client?

Therapists recognise both PQ and HAT as sources of information that helps client/family (Table 5). Regarding the particular advantages of the PQ, participants emphasised that it allows clients to specify and structure of their complaints, which is helpful for them (9; 39% of respondents). Therapists also reported that the PQ gives space for the client's point of view (5; 22%). As the most frequent advantages of HAT, therapists referred facilitating client reflection about the session (12; 50%), e. g., "*thinking about the session"*, and providing session-to-session and treatment outcome monitoring (6; 25%), e.g., *"the information may be used in order to give a more adequate therapeutic response to patient/family progress".*

Table 4. PQ and HAT: Advantages and disadvantages for the therapist

PQ			HAT		
Advantages for the therapist	**Freq**	**%**	**Advantages for the therapist**	**Freq**	**%**
Session to session outcome monitoring	9	38	Captures family/client feelings and opinions about sessions	8	33
To know the specific complaints of the client/family	8	33	Session to session outcome monitor	6	25
Using session to session outcome in clinical decision making	5	21	Immediate feedback of sessions	4	17
Pre-treatment case analysis	4	17	Integrates family/client point of view in clinical decision making	4	17
Relevant/useful additional information on cases	2	8	Relevant additional information on cases	4	17
Help establish relational systemic diagnosis (pre-treatment	2	8	Allows session evaluation	3	13
phase)	2	8	Allows therapist self correction	2	8
Saving time/number of sessions	1	4	Helps produce treatment overview writings	1	4
Help produce reports and treatment goals/progress	1	4	Suggests redefinition of treatment goals	1	4
Know individual family members resources	1	4	Captures intersession period changes	1	4
Perspective on family history	1	4	Offers rich perspective on family history	1	4
Warning emerging problem			Pre-treatment case analysis	1	4
			To know the specific complaints of the client/family	1	4
			Facilitates supervision sessions	1	4
			Allows research-practice integration as a routine	1	4
Total respondents	**24**	*	**Total respondents**	**24**	*
Disadvantages for the therapist	**Freq**	**%**	**Disadvantages for the therapist**	**Freq**	**%**
Exclusive focus on complaints	10	48	Time or human resources consuming	5	24
Therapist overload of information	5	24	Risk of exclusive focus on family/client perspective	3	14
Time or human resources consuming	3	14	Therapist overload of information	2	10
Anxiety of therapist in face of non-progress or deterioration	1	5	Exclusive focus on complaints	1	5
Confidentiality dilemmas	1	5	Anxiety of therapist in face of non-progress or deterioration	1	5
Relation therapist-researcher not clear for the client/family	1	5	Confidentiality dilemmas	1	5
Non-reliable information by the family/client	1	5	Relation therapist-researcher not clear for the client/family	1	5
			Non-reliable information by the family/client	1	5
			Exclusive focus on immediate effects of therapy does not capture medium long term effects of therapy	1	5
			Requires literacy skills	1	5
			Risk of therapy drop out due to research procedures	1	5
Total respondents	**21**	*	**Total respondents**	**21**	*

Note. Totals add values different from 100% because of multiple responses.

Table 5. PQ and HAT: Advantages and disadvantages for the client

PQ			HAT		
Advantages for the client	**Freq**	**%**	**Advantages for the client**	**Freq**	**%**
Allows for specification & structure of clients complaints: helpful	9	39	Promotes reflection about the session to the patient himself	12	50
for client	5	22	Helps session to session and treatment outcome monitoring	6	25
Gives space for clients point of view	3	13	Writing helps to organise and express thoughts	4	17
Facilitates therapist-family fit	3	13	Gives space for clients point of view	4	17
Helps clinical decision making	3	13	Helps clinical decision making	3	13
Helps session to session outcome monitoring: helpful as self			Allows for session summary	2	8
monitoring tool	3	13	Provides warning for emerging problems/themes	1	4
Helps session to session outcome monitoring: helpful for	2	9	Helps to establish relational systemic diagnosis	1	4
therapist	2	9			
Helps produce treatment goals/progress	1	4			
Helps to establish relational systemic diagnosis					
Allows for specification and structure of clients complaints: important information for the therapist					
Total respondents	**23**	*	**Total respondents**	**25**	*
Disadvantages for the client	**Freq**	**%**	**Disadvantages for the client**	**Freq**	**%**
Focus on complaints	7	33	Non reliable information by the family/client	3	14
Unrealistic expectations about the therapeutic process	3	14	Rationalisation	2	9
Non reliable information by the family/client	3	14	Stress and threat when he/she has trouble with reading and	2	9
Time or human resources consuming	3	14	writing	2	9
Excessive intervention/dispersed intervention	1	5	Confidentiality	2	9
Therapist overload of information	1	5	Time or human resources consuming	1	5
			Risk of therapy drop out	1	5
			Unrealistic expectations about the therapy	1	5
			Therapist overload of information	1	5
			Anxiety of client/family in face of non-progress or deterioration		
Total respondents	**21**	*	**Total respondents**	**22**	*

Note. Totals add values different from 100% because of multiple responses.

7. What are disadvantages do therapists perceive for the client?

Therapists referred to some disadvantages for PQ and HAT (Table 5). Regarding the particular disadvantages of the PQ, participants referred the focus on complaints (7; 33%). "*In a certain way it acts as a constant reminder of the problems identified by the patient", "Answering the PQ prior to every session may arouse problems that had been forgotten", "I don't believe that the questionnaire has problems, except when clients get the false expectation that it is a mandatory guide for the therapist".* As disadvantages of HAT, therapists referred to: Provision of unreliable information (3; 14%), time or human resources consuming (2; 9%), confidentiality (2; 9%), stress and threat when he/ she have trouble with reading and writing (2; 9%) and rationalization (2; 9%).

8. To what extent are therapists open to integrate PQ and HAT in her/his daily clinical work?

The majority of the participants (Table 6) said that they would like to integrate the information from PQ or/and HAT in their clinical work (PQ – 92%; HAT – 91%).

Table 6. Therapists openness to integrate PQ and HAT in their routine clinical practice.

	PQ		HAT	
	N	**%**	**N**	**%**
Therapists who would like to integrate PQ and/or HAT in clinical practice	22	92	21	91

Discussion

Results indicate that PQ and HAT have several advantages:

- Helping therapists monitor and enhance individual / family treatment response;
- Making adjustments to treatment in real time;
- Helping client/family think about in-session events and structuring problems and specific complaints;
- Providing therapists with a structured perspective of clients' complaints;

- Giving space for listening to clients' point of view.
- As disadvantages, some therapists feel that the use of PQ and HAT:
- Is time and human resources consuming;
- Might lead to the therapist overload of information;
- Could increase the risk of getting excessively focused on the family's / client's perspective;
- May provide therapists with unreliable information;
- May cause stress when the client has trouble with reading or writing;
- May raise confidentiality dilemmas.

Overall, results reveal that this small sample of therapists are open to using the PQ and HAT in their clinical practice, and see them as more useful than interfering. However, integration of these instruments as a routine procedure in mental health facilities may require adjustments. To what extent time and human resources requirements can prevent systematic use of PQ and HAT in mental health service delivery? In future surveys on this topic, it would also be important to address the question of the instruments' suitability to routine mental health service settings.

This study used internet-based recruitment and administration of measures, a relatively new data collection method. This had the advantage of saving time and resources and the convenience of having the data directly stored in an Excel database. There were, however, some disadvantages also, including limitations of the questionnaire design possibilities offered by the web-based software and inability to estimate response rate.

The present study has some limitations. We would like to point out especially the small sample size and the relative lack of experience that the therapists reported having had with PQ and HAT. It would have been also useful to have better discriminated among the possible contexts of use (whether in training centres or in professional health care service delivery settings), thus giving a more accurate picture of tools' practical applicability.

Nevertheless, knowing therapists' point of view about research instruments integrated into their work is an important step towards accurate and systematic evaluation systems where researchers and clinicians work together in order to deliver high quality psychological programs. We suggest extending these studies to other instruments used in routine naturalistic studies (e.g. Psychlops - Ashworth et al, 2005; CORE System, Evans et al., 2002). It seems also important to directly survey mental health consumers about their perceptions of these instruments.

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