Process & Outcome Research
SRC Resource 7

HOW DO YOU KNOW WHAT INPUTS WORK? - and HOW DO YOU KNOW HOW YOUR CLIENTS ARE DOING?

We are interested here in forms of Practice-Based Evidence: evidence derived from the therapeutic practice. **Process** measurements try to identify the variables involved in the actual changes that happen within the client's process of therapy; and **outcome** measurements try to identify the actual changes that have occurred as a result of the therapy. There are two major approaches: those that involve naturalistic settings and analogues of inquiry.

Naturalistic settings refer to the actual counselling sessions with real clients and can include: case studies; conversational analysis (which analyses the conversation in between therapist & client, in order to identify process variables); clients' expectations; and process variables, etc. These allow the researcher to generalise findings about the client's process, but they do not allow the researcher any control over confounding influences being measured.

Analogue research usually involves the use of artificially created therapeutic sessions to try to identify process variables and can involve watching a videotape of a mock session or reading a constructed transcript. Because it is a 'construct' or an 'analogue' of a therapy session, the researcher can control the process variables being measured, but the results are also more difficult to generalise to other people outside the study.

The **process variables** that can influence therapy include: initial interviews, the client's degree of openness and commitment, the therapist's responses, the formulation of a working therapeutic alliance; and other factors like the therapeutic setting, body-language, and in-session behaviour.

A measurement can be taken from when the client first came in the door; or even before the first session. The same measurement is then taken at intervals during the course of the therapy, (say) every 6th session. Hopefully, there is a steady improvement over the course of the therapy. One can then say that the therapy is **effective** – in that respect anyway. There are many types and forms of 'measurement', but whatever type is used, it should be used fairly consistently.

These types of measurement are different from diagnostic tools: those indicate whether the person has a particular problem and how serious that problem might be.

Ideally, one might also ask the client to agree to take the same measurement sometime after the therapy has stopped, (say) 3 months or 6 months later. Hopefully, the 'good effects' – the benefits – would have persisted. Then one can say the therapy is **efficacious**: that the benefits have lasted.

Process Research

This can be split into two branches: **enquiry** into the client's process, which can include both the covert and overt variables of the therapists and the clients involved. There are four major design decisions that have been identified in the literature that will determine the format of the process research inquiry: **(a)** what specific processes are being measured; **(b)** the number of counselling session(s) that will be used to examine the specific processes; **(c)** the perspective or vantage point from which the specific processes will be measured; and **(d)** how the gathered data on processes will be evaluated.

Focussing on specific processes include: the content of the sessions; what is done in the sessions; styles of the sessions; and the 'quality' of the sessions. There is also special 'skill' that is needed to rate these sessions: to identify and code the process variables and correlate the results.

Outcome Research

This is an essential tool in psychotherapy as it gives some sort of **evidence** that one's clients are improving: that your psychotherapy is effective – that it works! – that the people who come to you for therapy actually get better!

Outcome research seeks to evaluate the effectiveness of specific interventions or of the therapy itself. Some of the effects that can be measured by comparing are: **(a)** individual therapy to group therapy; **(b)** brief therapy to long-term therapy; **(c)** the effects of normal, regular therapy to control groups, and **(d)** these are identified through the use of quantitative instruments that measure specific outcome criteria: these variables indicate the amount of change in a specific area – such as client satisfaction; or changes in well-being, performance, problems and risk-factors. The outcome criteria data can be measured before the therapy has started; before and/or after a session; before and after a specific number of therapy sessions; and as a follow-up to the therapy.

As with process research, the researcher determines which outcome criteria to measure and how to measure these. However, the actual measures are influenced by the methods used in the study: outcome research does not use randomization, nor a control group.

An example of **Outcome Research**: using CORE-34: [1]

Showing 5 clients, each with CORE scores taken at the 1st and 6th session: the sessions are weekly. There are 34 measures – statements of how the client might feel or do over the last week; each measure has a 5-point Likert Scale: Not at all; Occasionally; Sometimes; Often; or Most or All of the Time (scored 0 – 4). There are 4 Domains: Well-Being (5 measures), Level of Problems (11 Problems), Level of Functioning (12 measures), and a Risk Factor (6 measures). Higher scores indicate more problems: a lowering of the scores indicates an improvement. A total score of 30 or below indicates a non-clinical profile.

Client	Age	Gender	Date	Session	Well-being	Problems	Functioning	Risk	Total	Change
Client 1	**34**	**M**	**11/1/21**	**1**	14	20	17	3	54	
			1/3/21	**6**	8	12	13	0	33	-21
Client 2	**17**	**F**	**7/1/21**	**1**	24	34	30	5	93	
			18/1/21	**6**	10	27	10	1	48	-45
Client 3	**48**	**F**	**8/2/21**	**1**	14	30	30	2	76	
			22/3/21	**6**	4	12	12	0	28	-48
Client 4	**60**	**M**	**9/3/21**	**1**	11	27	20	5	64	
			20/4/21	**6**	10	18	18	4	50	-14
Client 5	**52**	**F**	**9/4/21**	**1**	13	18	13	2	48	
			21/5/21	**6**	7	8	10	0	25	-23

In the table above, nearly all clients show an improvement, but – as can be seen – with **Client 4**, the improvement [*from 64 to 50: down 14*] was less than with others: possibly because he is aged 60, significantly, their Risk Factor remained quite high as well. **Client 1** (a 34-year old man) started with a moderately high total score (54), but – after 6 sessions – had come down, nearly to a non-clinical profile (33): [*down 21*]. **Client 2** (a 17-year old girl) started at a very high score (93) and come down a long way to a much better place (48) [*down 45*], but still with a way to go. **Client 3** (a 48-year old woman) started at quite a high level (76) and also came down massively [*down 48*] to a non-clinical level (28). **Client 5** started with moderate problems (at a total of 48) and came down quite nicely [*down 23*] to a non-clinical level. These are factual observations: i.e. quantitative. One can interpret them in a number of different (qualitative) ways.

[1] CORE-IMS: www.coreims.com