Emotion-focused therapy for social anxiety: A hermeneutic single case efficacy design study of a low-outcome case

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Background: *Hermeneutic single case efficacy design (HSCED) has emerged and developed as a rigorous psychotherapy research method for examining the effects of therapy in single cases (Stephen & Elliott, 2011). The effectiveness of Person-centred experiential (PCE) psychotherapies for treating Social Anxiety (SA) has been the specific focus of recent HSCED research, and initial findings have indicated that various strands of PCE therapy have potential to be effective treatments for SA (Stephen, Elliott & MacLeod, 2011; MacLeod, Elliott & Rodgers, 2012).*

Methodology: *HSCED was applied to a low-outcome case in which an individual presenting with SA received 20 sessions of Emotion-focused therapy (EFT). A rich case record, and set of affirmative and sceptic arguments – arguing for and against client change – were developed, based on a body of qualitative and quantitative data gathered over the course of the client's therapy.*

Findings: *The client showed evidence of a slight to moderate degree of change. In addition, his therapy was judged to have had a clear but modest effect on outcome.*

Discussion: *Findings, and wider implications for the application of HSCED, are highlighted and discussed.*

Keywords: *Social anxiety; Hermeneutic single case efficacy design; Emotion-focused therapy; Person-centred therapy.*

Background to HSCED

HERMENEUTIC single case efficacy design (HSCED; Elliott, 2002b) has emerged as a robust method for evaluating the efficacy of therapy in single cases, with a new wave of HSCED studies being published in recent years (Stephen & Elliott, 2011). HSCED was proposed as a practical reasoning system that aims to establish whether the client changed, whether therapy had a causal role in client change, and what processes brought about client change. Qualitative and quantitative measures are applied to create a rich and comprehensive body of data, giving a multi-faceted picture of the client's process and outcome before, during, and after therapy. Elliott et al. (2009) demonstrated an adjudicated or legalistic version of HSCED. They argued that the application of the legal model offers a more powerful and rigorous method for bringing out arguments and clarifying ambiguities in single cases. In this model, affirmative and sceptic cases are constructed and presented to a panel of judges, who must consider the data in terms of the research questions. This movement within the field of single-case research offers a credible and complementary alternative to the Randomised Control Trial (RCT) model that continues to dominate discourse and policy-making around evidence-based practice (Fishman, 1999; Miller, 2004; Watson, Goldman & Greenberg, 2007).

Stephen and Elliott (2011) have pointed out that lack of generalisability remains the most common criticism of single case studies. Bohart and Humphreys (2000) and Fishman (1999) have recomended establishing a set of

conditions needed in order for change in therapy to take place; these conditions can, over time, form generalisable maps or guidelines to inform clinical practice and treatment decisions. All of these authors propose that this difficulty regarding generalisability can be addressed through the completion of multiple single cases, leading to a body of case law that sets a precedent for certain client presentations and treatment pathways. McLeod (2010) recommends completion of case studies across the full spectrum of clinical presentations and outcomes – covering good outcomes and poor or disappointing outcomes – in order to create a broad and rich body of evidence on which generalisation can be based.

Such thinking reflects Watson, Goldman and Greenberg's (2007) multiple single case study of emotion-focused therapy (EFT) for depression. They examined three high-outcome and three low-outcome cases from a larger RCT sample, arguing that developing an awareness of factors that may underlie poor or disappointing outcome, as well as more high outcome cases, can help us gain increased understanding of which clients are likely to benefit from specific treatments in specific contexts. Watson et al. identified a number of client factors that were shared across high-outcome cases as opposed to low-outcome cases, with the objective of providing some understanding of the basis of common factors leading to therapeutic progress or inhibition. Client willingness to self-disclose, the clear identification of a problem, a willingness and capability to act on new realisations outside of sessions, and a capacity to access adaptive emotions and self-compassion were common factors among good outcome cases. Factors common among poor-outcome clients included a lack of vividness in narratives, difficulty accessing and labelling emotions, and the absence of the belief that their situation could actually improve. These conclusions can be conceptualised as the beginning of a wider system of understanding and generalisability, which provides some context for thinking about treatment for such presentations.

Recent HSCED studies have examined the application of Person-centred experiential (PCE) therapies with various anxiety disorders. HSCED, as a scientific tool, represents an excellent match to PCE therapies on a philosophical level, as its emphasis on the client's own narrative and understanding of their experience is congruent with PCE therapies' agenda of prioritising the client's phenomenological experience. Findings have indicated that EFT can be an effective treatment for both panic disorder (Elliott et al., 2009) and social anxiety (MacLeod, Elliott & Rodgers, 2012), and that classical Person-centred therapy can, to some extent, be an effective treatment for social anxiety (Stephen, Elliott & MacLeod, 2011). While it is by no means possible to state conclusively that these particular strands of PCE therapy are effective treatments for these particular anxiety difficulties, these results show that the interventions can, at least under certain conditions, bring about positive therapeutic gains for individuals presenting with these forms of anxiety.

EFT for social anxiety

EFT regards emotion as central to psychological functioning, experiencing and change, and proposes that it is through altering the use of emotions that clients' problematic self-organisations can be changed (Elliott et al., 2003). The approach utilises a range of process-guiding therapeutic tasks – such as focusing, unfolding and chair-work – aimed at addressing specific emotional processes, entwined with the therapist inhabiting each of Rogers' (1957) core conditions. In EFT terms, social anxiety is understood as the function of maladaptive emotion schemes, which have usually developed as a result of the individual having experienced criticism, humiliation or shame in relation to their social presentation. This may lead to the development of an emotion scheme that associates social interaction with physical danger and

humiliation, thus triggering responses of fear and shame in the here-and-now. EFT addresses this process by helping clients move from secondary reactive emotions (anxiety, emotional pain) to primary maladaptive (overgeneralised) emotions (shame, depression), and finally to primary adaptive emotions (e.g. connecting sadness, protective anger, self-compassion). In an HSCED study of EFT for social anxiety, MacLeod, Elliott and Rodgers (2012) concluded that EFT had been a successful treatment for that particular case, based on the consensus of three judges. Their results pointed to a strong therapeutic relationship, and the application of key EFT therapeutic tasks (Focusing, Two-chair work and Empty-chair work) as key therapeutic components that contributed to the client's positive change. Of course, these findings by themselves cannot be generalised to the wider population of clients with SA, but they undoubtedly evidence the possibility that EFT can be an effective treatment for SA, with these named elements of the therapy likely to be particularly important change processes.

Elliott and Rodgers (2010) have produced pilot quantitative group outcome results indicating substantial pre-post gains for clients receiving person-centred experiential therapy (PCET) for social anxiety, comparable with existing evidence of the efficacy of cognitive behavioural therapy (CBT). This adds to the evidence for the efficacy of PCE therapy for treating individuals experiencing social anxiety, depression or post-traumatic processes generated in the field of single case research (MacLeod, Elliott & Rodgers, 2012; Stephen, Elliott & MacLeod, 2010; Elliott, Greenberg & Lietaer, 2004; Goldman, Greenberg & Angus, 2006).

In light of McLeod's (2010) recommendation that HSCED studies be carried out across the spectrum of therapeutic presentations and outcomes in order to increase generalisability, this paper considers a single case where quantitative data indicated a low-outcome result. In keeping with the streamlined approach recommended by Elliott et al. (2009) and applied by MacLeod, Elliott and Rodgers (2012), the rich case record and affirmative and sceptic sides were all competed by the same researcher (also the first author). These were used to answer, in this particular low-outcome case, whether the client changed substantially; whether any observed changes were due to the effects of EFT, and which mediator and moderator variables might account for any changes observed.

Method

Participants

Client. The client was selected from the Strathclyde Therapy Research Clinic Social Anxiety Study data archive, within a research protocol approved by both University of Strathclyde and West Glasgow NHS research ethics review committees. Selection was informed by examining the range of post-therapy outcomes for the first 20 clients using residual gain scores (controlling for pre-therapy scores) on the main outcome measure, the Personal Questionnaire (see below). The client with the lowest residual gain score who had received EFT was thus selected.

'Ross' (a pseudonym) was in his mid-30s. He was single, had no children, and had never been in a long-term relationship. He had been receiving psychiatric treatment for depression for nine years prior to entering the present therapy. Ross was living in fear of becoming a victim of violence, and in fear of rejection and humiliation by others for his inability to initiate or maintain conversations, especially with attractive women. He had worked full-time in a job that he described as 'advantageous', but had been off work due to depression for the two weeks leading to his presentation for therapy. He received 20 sessions of EFT.

Researchers. The researcher was a member of the Social Anxiety Research Project at the University of Strathclyde. This research team included postgraduate students on the

University's Diploma in Counselling and Doctorate in Counselling Psychology courses, plus other therapeutically-trained research associates.

Therapist. Ross was seen by a PCE counsellor, with 15 years' experience of working therapeutically with individuals, families and couples. She was working in the EFT arm of the Social Anxiety Research Project.

Author and Judges. The author-researcher did not act in the capacity of therapist or researcher for the client. She transcribed the change interviews, compiled the rich case records and composed the affirmative and sceptic arguments. All of the documents were edited by the research supervisor/second author before being passed to the judges. The author-researcher was a final year counselling psychology doctoral student, who also had a diploma in counselling. She considered herself to be essentially a person-centred practitioner and researcher, though also trained and experienced in CBT and EFT.

Two of the judges were final-year counselling psychology doctoral trainees who were experienced in various strands of the Person-centred approach and CBT. The third judge was a clinical associate in applied psychology for children and young people, working in a hospital setting. Her therapeutic training was informed primarily by a cognitive-behavioural approach, with some training in systemic approaches and play therapy. The appointment of this set of judges was in line with the precedent emerging in HSCED research for using judges who are not overly-committed to any one theoretical approach, but have a basic competence in psychology and research methods. Such individuals meet the legal definition of a reasonable person, and thus are an appropriate choice for participation in an adjudicated research process (Bohart & Humpreys, 2000; MacLeod, Elliott & Rodgers, 2012).

Client Screening. Ross participated in a two-phased assessment to determine his inclusion in the study. This comprised a 20-minute telephone screening, followed by two two-hour face-to-face diagnostic assessments using *DSM-IV* axes I and II. The Structured Clinical Interview for *DSM-IV* (SCID; First et al., 2007), Personality Disorders Questionnaire IV (Hyler, 2007), Social Phobia Inventory (SPIN; Connor et al., 2000) and Personal Questionnaire (PQ; an individualised outcome measure; Wagner & Elliott, 2001) were completed. Results indicated that Ross met the criteria for a diagnosis of Social Anxiety, in the absence of any other major psychiatric disorder.

A simplified Personal Questionnaire (PQ; Wagner & Elliott, 2001) was used to establish a subjective list of the Ross's problems as he saw them, and their duration across his lifetime. This list was used to formulate a client-specific quantitative measure.

Measures: Developing a Rich Case Record

The following sources of data were used to compile the Rich Case Record: Quantitative outcome measures applied (citations providing psychometric information are given in parentheses) were the Clinical Outcomes in Routine Evaluation – Outcome Measure (CORE-OM; a general outcome measure; Barkham et al., 2001); the Strathclyde Inventory (SI; a positively-scored Person-centred measure of congruence/incongruence; Freire, 2007); the Personal Questionnaire (Wagner & Elliott, 2001); the Social Phobia Inventory (SPIN; a standard measure of social anxiety symptoms; Connor et al., 2000); and the Inventory of Interpersonal Problems (IIP; a standard measure of interpersonal problems; Horowitz et al., 1988). Ross completed each of these measures before session 1, after session 8 and at the end of therapy. All measures used have good/excellent validity and reliability.

These measures were evaluated using clinical significance and reliable change, as described by Jacobson and Truax (1991). The requirement of near certainty (i.e. $p<.05$) is not always appropriate in the context of case study research, where it typically reasonable

to think in terms of 'reasonable confidence' (which can be defined as $p<.2$) as opposed to near certainty ($p<.05$). This has become an established precedent in previous HSCED research (Elliott 2001; Elliott et al., 2009; MacLeod, Elliott & Rodgers, 2012). In order to infer Global Reliable Change, at least two outcome measures are required indicate Reliable Change between pre- and post-therapy stages (Elliott, 2001).

Ross completed the PQ before each session, providing a weekly quantifier of his distress in relation to his main therapy-related difficulties. He also completed a weekly Helpful Aspects of Therapy (HAT) form, a qualitative measure identifying elements of the sessions that the client found to be particularly helpful or unhelpful (Llewelyn, 1988).

Ross participated in a semi-structured interview (the Change Interview; Elliott, Slatick & Urman, 2001) after eight sessions, and again at the end of his therapy. The interviews included questions about his experiences of therapy, what changes he might have experienced in himself and his difficulties over the course of therapy, and how these changes may have affected various domains of his life outside of therapy. The interview asks clients to rate specific changes on partially anchored five-point scales. Ratings are given for the extent to which reported changes were expected (1='expected' to 5='surprising'), how likely the client thought it was that these changes would have taken place without therapy (1='likely without therapy' to 5='unlikely without therapy') and how important each of these changes was to them (1='not at all important' to 5='extremely important'). He was also asked about events or changes outside therapy that may have affected his processes, such as changes in social circumstances, economic circumstances, relationships or medication.

The Therapist Experiential Session Form (TESF; see Elliott, 2002, for psychometric data) is a 66-item quantitative measure of therapist application of key elements of EFT in-session. This measure was completed by the therapist after each session. Results were correlated with the client's weekly PQ outcome scores in order to test whether particular theoretically important in-session processes were associated with a shift in Ross's problems.

Based on the HSCED procedures proposed by Elliott (2001), affirmative and sceptic cases (based on positive/direct evidence and negative/indirect evidence respectively) were developed. These were based on the evidence presented in the rich case record. Both cases comprised an initial brief, a rebuttal to the brief of the opposing side, and a final narrative summing up the proposed client journey from that point of view.

Judging process

The judges were presented with the rich case record, and briefs, rebuttals and narratives for both affirmative and sceptic sides. They also received a transcript of Ross's post-therapy Change Interview (included in the Rich Case Record). Judges were provided with written instructions on how to approach the documents, and a form on which to document their conclusions to the following questions:

- To what extent do you think the client changed over the course of therapy?
- How likely do you think it is that the client showed at least 'substantial' change over the course of therapy?
- To what extent do you think that the client's changes were due to the therapy?
- How likely do you think it is that the client's changes were at least 'substantially' due to therapy?

The judges were asked to record their judgements on each of these questions as a percentage score ranging from 0 per cent to 100 per cent. Judges were also asked to comment on which parts of the evidence they found most convincing in reaching their conclusions, and which client and therapy processes they believed to have been most important in the process.

Results

Summary of Rich Case Record

It has been the case in some earlier HSCED publications that a complete account of the Rich Case Record is published, but in this case a summary of the main points is given. The complete rich case record, along with all briefs and rebuttals, can be obtained from the first author.

Outcome. Ross's outcome data are summarised in Table 1. Ross was in the clinical range on each of the quantitative measures when he entered therapy, and remained there with no clinically significant shifts from pre- to post- therapy. Despite showing no statistically significant movement, Ross showed small positive gains on each of the five measures.

Ross's Personal Questionnaire items, ratings and duration are detailed in Table 2. The overall pattern of his PQ scores is illustrated in Figure 1. Ross's PQ score fell by 0.77 over therapy, but this did not amount to reliable change, and he remained in the clinical range on the measure throughout.

During the Post-therapy Change Interview (detailed in Table 3), Ross identified three changes that took place for him over the course of therapy. These were an improvement in his mood, a reduction in physical anxiety symptoms and his becoming more externally-focused and talkative. He rated each of these changes as 'extremely important' and 'unlikely without therapy.' He said that two of the changes were 'somewhat expected' and the third change was 'somewhat surprising'.

On the HAT Form, Ross rated three in-session events as either 'very helpful' or 'extremely helpful'. Ross rated the therapeutic experience of understanding the exact nature and function of his self-critical SA-related thoughts as 9 ('extremely helpful'). He rated the use of two-chair work with his inner critic and talking about having had a difficult few days as 8 for helpfulness.

Summary of arguments

As with the Rich Case Record, a summary of the main points in each of the arguments is presented in this instance. Copies of the Affirmative and Sceptic Briefs can be obtained from the first author.

Affirmative Brief. The Affirmative Brief set out to demonstrate that Ross did change over the course of therapy, and that EFT was the main cause of this change. The Brief highlighted that Ross identified three broad

Figure 1: Mean PQ scores across sessions.

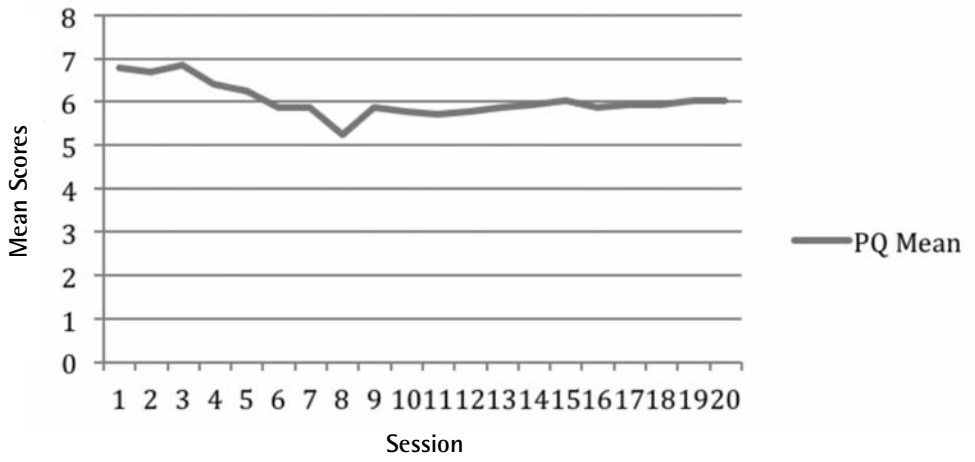

Table 1: Quantitative outcome data.

Measure	Cut-off	RCI Min*	Therapy Stage	
			Pre	Post
PQ	**<3.5**	1.0 (↓)	**5.85**	**5.08**
SPIN	**<1.12**	.67 (↓)	**2.59**	**2.35**
CORE	**<1.25**	.50 (↓)	**2.47**	**2.21**
SI	**>1.69**	.46(↑)	**0.94**	**1.23**
IIP	**<1.5**	.57 (↓)	**2.19**	**1.73**

*p<.2, **p<.05
Note. RCI Min*=minimum client change that exceeds measurement error at p<.2. Values in **bold** are in the clinical range. ↑ = increased score indicates positive change according to measure. ↓ = decreased score indicated positive change according to measure.

Table 2: PQ item duration and ratings.

Item	Problem Duration	Severity at Therapy Stage		
		Pre	Mid	Post
I fear attractive women	>10 years	7	6	6
I fear all people	>10 years	6	6	6
In social situations I get physically tense, anxious and nervous (particularly in my stomach) and my attention turns inwards which then creates even more tension, anxiety and nervousness within me	>10 years	6	6	6
I fear rejection and/or ridicule	>10 years	6	6	6
I experience too much anticipatory anxiety when I know I'm going to be the centre of attention	>10 years	5	6	6
When I am the centre of attention I am over anxious, nervous and tense	>10 years	5	6	6
I have a very low self-image	>10 years	7	5	6
I fear violence against myself when I'm out in pubs/clubs at evening/night, particularly out on the street between venues	>10 years	6	5	5
The nerves in my stomach are always overactive	>10 years	7	6	6
I eat too much	>10 years	6	5	1
I smoke too much	6–10 years	6	1	1
I feel depressed most of the time	>10 years	5	5	6
I sometimes blush when I am in front of attractive women	>10 years	4	5	5

Note. Items were rated on a 7-point scale, from 1=not at all, to 7=maximum possible.

Table 3: Summary of client changes and ratings at Post-therapy Change Interview.

Change	Level of surprise at change[a]	Likelihood without therapy[b]	Importance of change[c]
Reduction in social anxiety – physical symptoms	2 (somewhat expected)	1 (very unlikely without therapy)	5 (extremely important)
Reduction in depression – improved mood	2 (somewhat expected)	1 (very unlikely without therapy)	5 (extremely important)
More externally-focused and a bit more talkative	4 (somewhat surprised)	1 (very unlikely without therapy)	5 (extremely important)

[a] 5-point rating scale: 1 = expected, 3 = neither, 5 = surprising
[b] 5-point rating scale: 1 = unlikely, 3 = neither, 5 = likely
[c] 5-point rating scale: 1 = not at all, 3 = moderately, 5 = extremely

changes in his Post-therapy Change Interview, and that he rated each of these as 'very important' and 'unlikely' to have occurred without therapy. It pointed out that each of the therapeutic processes that Ross identified as helpful shared the common theme of his gaining a deeper sense of and connection with his own emotions. It was argued that the changes Ross identified in the Post-therapy Change Interview mapped onto the responses he had given on the HAT Form, and that this demonstrated clear links between the specific therapeutic processes that took place and the eventual cumulative gains described. The Affirmative Brief emphasised Ross's identification on the HAT Form of two-chair work, exploring his inner critic and sharing his emotional experiences (all key components of EFT) as particularly helpful. The overall drop in PQ score, though not statistically significant, was noted as representative of positive change. It was noted that his PQ score dropped after each of the sessions rated most helpful on the HAT form.

The Brief also pointed to positive correlations between Ross's problem shifts and the therapist's post-session ratings of two key EFT elements (*Non-confrontationally describe in-session verbal or non-verbal behaviour:* r=.57; p<.05, and *Encouraging the client to check representation of experience with actual experience:* r=.34; p<.3). It was argued that the observed downward shifts in chronic problems (as documented in the PQ) were unlikely to be the result of spontaneous improvement, and best explained by Ross's engagement with EFT.

The Affirmative Brief noted that during the Post-therapy Change Interview, Ross disclosed that he had made arrangements to continue EFT with a different therapist in a private context. It proposed that this further evidenced his experiencing meaningful change by means of the approach.

Sceptic Brief. The Sceptic Brief highlighted that Ross remained in the clinical range across all measures and asserted that this evidenced that any observed gains were trivial. It emphasised that his quantitative outcome scores were nowhere near sufficient to infer Global Reliable Change and concluded that there was no statistically significant quantitative evidence to support a hypothesis that positive change took place.

The Sceptic Brief called into question the reliability of Ross's qualitative account of his own change, proposing that his giving a positive account was actually a function of his difficulties. It suggested that, as someone

with SA who feared rejection and was nervous around women, his giving a positive account to the female researcher about his work with a female therapist was inevitable. The Brief cited Bohart and Boyd's (1997) argument that the credibility of a client's account of their own change can be measured by the extent to which the effect of the therapy is elaborated in the narrative, and it argued that Ross's account of his own change was short on detail and high in repetition. It also noted that Ross disclosed during his Post-therapy Change Interview that he had entered therapy with high expectations as he had read up on EFT and was familiar with some of its terms. It was argued that his initial expectations further coloured his appraisal of his own process, and compounded his tendency to form a positively-biased view of his therapeutic experience.

Affirmative Rebuttal. The Affirmative Rebuttal acknowledged the absence of Global Reliable Change on the quantitative outcome measures. However, it asserted that the overall trend of therapeutic gains consistently evident across the quantitative measures must be taken into account. The Affirmative Rebuttal asserted that, despite being repetitive in places, Ross's account of his own change contained clear and concrete examples of how he felt he had changed, with a level of elaboration and detail that was more than sufficient. It also highlighted that Ross's account of therapy was not exclusively positive, as one might have expected if his reporting was the function of his SA processes, as suggested in the Sceptic Brief.

Sceptic Rebuttal. The Sceptic Rebuttal reasserted that no statistically significant change was seen and highlighted that this was the case across all five quantitative measures even at the relaxed $p<.2$ level of significance.

It also suggested that Ross's identification of working on emotion as a helpful element of his therapy was based on his face-value assumptions about what the researcher and the wider Strathclyde Research Project might want to hear from him. The Rebuttal cited Ross's known tendency to attach to certain therapeutic approaches for long periods of time (he disclosed in the Post-therapy Change Interview that he has previously had CBT for nine years). It argued that his seeking further EFT was merely a function of this tendency, and that it should not be mistaken for evidence of the effectiveness of EFT in this case.

Judgements. The extent and substantiality of Ross's change over the course of therapy were each judged at a mean of 33.3 per cent across the three judges (range 20 to 40 per cent). In other words, the judges rated the extent of Ross's change over therapy as between 'slightly' and 'moderately', concluding on average that there was only a 33 per cent probably that Ross had changed 'substantially' (range 20 to 60 per cent). On average, the Judges rated the contribution of therapy to Ross's changes as between 'moderately' and 'considerably' (53 per cent; range 20 to 80 per cent), concluding that there was a 53 per cent probability that Ross's changes were 'substantially' due to therapy (range: 20 to 80 per cent) (Table 4).

Table 4: Judges' ratings.

Judge	1	2	3	Mean; SD
Extent of change (%)	40	40	20	33.3; 11.5
Substantiality of change (%)	20	60	20	33.3; 23.1
Change due to therapy (%)	20	80	60	53.3; 30.6
Substantiality of role of therapy (%)	20	80	60	53.3; 30.6

The judges identified the following EFT processes (mediator factors) as helpful in bringing about change:

- A warm and consistent therapeutic relationship/working alliance (including acceptance, empathic understanding and care from the therapist).
- The use of distinctive EFT tasks such as two-chair work.
- Being able to share past experiences in a non-judgemental setting.
- Engaging in a social manner with the therapist.
- Practising social skills/role playing (two judges).
- The therapist offering hope (via disclosure of positive results with another client with SA processes).
- Highlighting and accepting dualities of the client's personality.
- Heightening awareness and recognition of current feelings and emotions.

Judges identified the following non-therapy (moderator) factors as:

- Making the decision to commit to therapy.
- Being willing to engage and talk openly in therapy.
- Having realistic expectations for therapy.
- Believing that therapy could be beneficial.
- Having an awareness of own needs, to give focus in therapy.
- Eagerness to read and learn about the EFT approach.

Discussion

Collectively, the judges' ratings indicate the following: (a) Ross's pre-post change failed to meet an 80 per cent probability of substantial change, but nevertheless showed evidence of a lesser degree of change; (b) A preponderance of the evidence (>50 per cent) suggests that his therapy had a clear but modest effect on his outcome. However, this apparent consensus overlooks the judges' wide-ranging conclusions, with individual judges' ratings showing a sizeable range on each of the research questions (Table 5). For example, while the overall extent of change was 33 per cent, two judges rated the substantiality of that change as 20 per cent, while the third judge rated Ross's change at 60 per cent. Ratings for both the role of EFT and substantiality of the role of EFT in bringing about change showed an even wider range, between 20 per cent and 80 per cent, indicating a notable split in judges' analysis and conclusions on some dimensions.

Judges viewed a Rich Case Record, which documented in detail qualitative and quantitative data gathered from the beginning to the end of Ross's therapy. They were presented with affirmative and sceptic arguments, which proposed the case for and against client change and the role of therapy in any change that took place. The sceptic position aimed to prove that the client had not actually changed to a significant degree, and that any change observed was minimal and trivial. It emphasised shortages, inconsistencies and limits to quantitative data, particularly the absence of a clinically significant drop on any of his five quantitative outcome measures. It argued that Ross's favourable retrospective account of his experience of therapy was unreliable, and a function of his SA, as his SA processes would make it extremely difficult for him to deliver a negative account of his therapy face-to-face to a researcher working on the study.

This case was systematically selected based on it showing the lowest pre-post improvement (residual gain scores) of clients receiving EFT in the larger study (total N=18 completed cases). Statistically significant evidence of positive gains on multiple measures was clearly absent. After completing the judging task, one judge commented that he had enjoyed reading what he called the 'scathing' sceptic side. Though made informally and in passing, this comment nevertheless clearly indicates the weight and conviction with which the arguments of the sceptic side were articulated. Despite these factors, judges' mean ratings point to Ross having made at least some gains in therapy. Despite the discrepancy across their individual conclusions, none of

Table 5: Judges' identified key aspects of therapy leading to client change.

Helpful Therapy Processes	Judge Identifying
Warm and consistent therapeutic relationship/therapeutic alliance	2
The use of distinctive EFT tasks	2
Acceptance from the therapist	2
Empathic and caring relationship	2
Sharing past experience in non-judgemental setting	1
Engaging in a social manner with the therapist	1
Practising social skills/role play	2 and 3
The therapist offering hope (via disclosure of positive result with another SA client)	2
Highlighting and accepting dualities of his personality	3
Heightening awareness and recognition of current feelings and emotions	3

judges concluded that Ross had made no gains whatsoever in therapy. Judges reported having been influenced by Ross's qualitative accounts of his change – particularly the Post-therapy Change Interview transcripts – and by some non-significant quantitative evidence of gains, in reaching those conclusions. Judges' utilisation of the multiple forms of evidence provided to draw their conclusions highlights the value of evaluating single cases within the context of a rich data set and extensive qualitative accounts. The full picture of the client's journey through therapy comes under analysis in this design, and judges' opportunities to connect with this using their clinical, professional and human experience allows for identification and discussion of subtle factors at play in the process.

In early session HAT Forms, Ross noted the experience of simply feeling he was listened to and acknowledged this as a helpful factor. Having his experience met without criticism, and being offered validation was later noted as helpful. The judges identified the provision and development of a warm and consistent therapeutic relationship, characterised by acceptance, empathic understanding and care, as the primary mediator of change in Ross's case. This replicates the findings of MacLeod, Elliott and Rogers (2012), who identified the provision of Rogers' (1957) core conditions for therapeutic change as central to generating progress for an individual presenting with SA. As MacLeod et al. (2012) note, this may seem a somewhat counter-intuitive finding, given that interpersonal and relational difficulties are at the heart of SA processes. However, the consistent emergence of this theme may indicate that the PCE approaches, and particularly the elements of empathy and unconditional positive regard (which, of course, rely on the presence of congruence), offer a helpful therapeutic match with the needs of individuals experiencing SA. SA is largely characterised by fears around being judged negatively, or shamed by others. It follows from this that, if the risk of fear or shame is removed from the interpersonal interaction – as it should be in any strand of PCE therapy – the client can move towards freedom and congruence, and a consequent reduction in symptoms.

Ross singled out accessing and exploring his 'inner critic' (a central EFT concept) as the single most helpful aspect of his therapeutic experience. The judges pointed to this, and it being worked with using a two-chair dialogue, as an additional instigator of change. Again, this replicates the findings of MacLeod, Elliott and Rodgers (2012) that

two-chair work (along with experiential focusing and empty-chair work) served an important function in client change processes. It is important to be cautious, however, when analysing clients' reports of helpful therapeutic processes after a course of EFT. At face value, the present results in the context of MacLeod et al.'s (2012) conclusions indicate that that the specific EFT task two-chair work emerges consistently as a very helpful element of treatment for SA. However, we must consider that these findings are based on narratives provided by clients who presented with chronic and severe SA problems. Two-chair work is an unusual and memorable therapeutic experience, and is likely to remain a salient memory of therapy after the experience has passed. In light of this, clients who may be inclined to give an overly-positive account of therapy (possibly as a function of SA processes) may be more likely to reach for a salient and unusual moment of therapy when asked for a specific example of what was helpful. Our aim is by no means to cancel out clients' positive accounts of two-chair work and other salient components of EFT, but to encourage a note of caution in approach to these conclusions.

The relationship between EFT and outcome

The present case differs in therapeutic outcome from the earlier case of EFT for SA reported by MacLeod, Elliott and Rodgers (2012). Comparison of mediator variables identified in both cases shows therapeutic gain to be associated with a strong therapeutic relationship – built on empathic understanding and acceptance – and the application of two-chair work. However, it is also evident that the presence of those factors alone is not consistently sufficient to bring about significant change for the client, as these were present in the case of Ross, where statistical outcome was low. In the previous (high-outcome) case, additional EFT tasks (Focusing and Empty-chair work) were identified as mediator variables in addition to what has emerged in the present case. This could be taken to indicate that these strands of EFT were a better fit for that particular client's experience (e.g. using empty-chair work to process unfinished business) in a way that was not present in the latter case. Of course, we must also acknowledge the potential for some diversity across individual therapists' application of certain EFT tasks, and their vigilance for markers for their appropriate introduction in-session.

There are considerable differences in moderator variables emerging across these two cases. In MacLeod, Elliott and Rodgers's (2012) high-outcome case, judges concluded that no events or relationships in the client's life outside therapy made a substantial contribution to therapeutic outcome. The authors acknowledge in their reporting of that case that it is unusual for clients to go through the therapeutic process having no extra-therapy relationships or life circumstances penetrating the therapeutic process to a significant degree. However, judges in that case did highlight the client's willingness to engage with the therapeutic process, and to be open in sharing her experience, as important in her positive change. By comparison, multiple moderator factors were identified in the present case. Again, a willingness to engage with the therapeutic process emerged as a main moderator variable, mirroring MacLeod et al.'s earlier findings. This consistent factor points to client willingness to commit to therapy, and perhaps to remain with it at difficult times, as an important moderator factor for change.

In the present case, Ross's expectations that EFT could have helped him, and his being knowledgeable about EFT, was also identified as a moderator outcome for change. On the one hand, it stands to reason that positive expectations of therapy would be important for initial engagement, and thus a good outcome. However, the present findings point to the possibility of a connection between poor outcome and the client being very knowledgeable and well-read about the therapy in which he is engaging. Ross rated two out of his three changes, as

identified in the Post-therapy Change Interview as 'somewhat expected.' This highlights that he entered the process with a certain set of expectations about EFT, and what it might do for him. This could indicate the potential for clients' positive expectations of therapy to pose a certain degree of risk to eventual outcome, if these expectations are particularly great. There is a possibility entering therapy with a strong knowledge of how the process works and its reported effectiveness can cause a shift of a client's locus of change away from themselves and towards the therapist or the therapeutic process. The present outcome could be partially explained by Ross having imparted more faith than was helpful in EFT, causing him to reduce the extent to which he relied on himself and his own resources to participate in the change process.

The application and development of HSCED

Following the proposal of McLeod (2010) for case study research to encompass cases across the full spectrum of outcome, it was hypothesised that, by widening the lens of case study research to low-outcome cases, awareness could be developed of factors that may underlie poor or disappointing outcome. Despite the deliberate step to select a low-outcome therapy case in this instance, Ross's case generated conclusions in favour of EFT; none of the judges concluded that Ross did not change or that he worsened as a result of EFT. This meant that no factors felt to be instrumental in leading to low outcome were named; judges' assessments and conclusions focused exclusively on factors that were felt to have been helpful. Judges were not directly asked to specify moderator factors of low outcome, and it is possible that the positive focus of the research questions may have biased their approach to the evidence. It is possible that the inclusion of a more negatively-orientated questions may have focused judges on such aspects of the evidence, and highlighted therapy or non-therapy factors that they believed to have contributed to a low outcome. This shortcoming points to a limit to the use of a standardised form of HSCED as a tool for investigating causes of clients' change when change is minimal or negative. So far, published HSCED studies have been limited to high- or moderate-outcome cases. The approach has yet to be challenged to meet fully the demands of poor or disappointing-outcome cases. Further testing and development of the HSCED approach, and particularly the judging process, may be required in order to maximise the meaningful findings from HSCED at this end of the outcome spectrum.

Ross's results revealed no statistically significant change across the five quantitative outcomes measures, whereas his qualitative account of his own process ascertained that positive change did take place. The discrepancy between various data soucres formed the heart of the debate between the affirmative and sceptic sides in this case, and represents a relevant and under-addressed debate in psychotherapy research (Elliott, 2002b). MacLeod, Elliott and Rodgers (2012) suggest that, if qualitative and quantitative data contradict each other, then the form of data most consistent with the philosophical base of the theoretical approach within which the research is taking place ought to be prioritised. HSCED has its roots firmy in PCE psychotherapy (Elliott, 2001), which strives to prioritise and engage with the client's phemonenological experience. MacLeod et al. (2012) suggest that, in light of this, the client's qualitative data should be given precedence in this context. They report a case in which the post-therapy change interview and judging process took place prior to a four-session consolidation phase. At the judging stage of that case, the client's narrative claimed significant gains over the course of therapy, but this was not wholly reflected in her quantitative outcome scores. However, when she completed a further battery of outcome measures after the consolidation phase, her quantitaive scores were found to have converged with her earlier narrative account. MacLeod et al.

suggest that this evidences the credibility of prioritising clients' accounts. This appears to have been what the judges did in this case, taking heed of Ross's own narrative, despite the absence of quantitative data to support it. This seems to indicate the initial development of a precedent in this direction, for HSCED research.

The low level of unanimity observed between the judges shows that they worked on their assessments and conclusions independently, and within their own unique frames of reference. On the one hand, this pre-emptively addresses criticism that the favourable result for EFT may have been the result of judges' theoretical allegiances (Luborsky et al., 1999). Despite two of the judges having considerable training and experience in various strands of PCE therapy, including EFT, the role of therapy in bringing about change was judged by one judge at 20 per cent and another at 80 per cent. It stands to reason that, if allegiances had been dominating judges' responses, a more pronounced trend might have been visible across their conclusions. Indeed, the level of discrepancy in judges' individual conclusions highlights that calculating and reporting mean percentages across the three judges has the potnetial to be somewhat misleading in that it fails to truly represent the views of any one judge. In this study, judges worked independently, and did not discuss their assessment of the evidence with each other or anyone else. However, if HSCED is to remain true to the legal model to which it aims to adhere, it may be more appropriate in future studies to have judges working together, and exposed to each other's interpretations and beliefs in response to the evidence before being asked to give only one verdict, spoken with one voice. That way, results have a clarity that allows for more robust conclusions to be drawn, and are reflective of the jury system that currently dominates societal judgements and decision making.

It is acknowledged that the present HSCED does not offer a sufficient or exhaustive body of evidence to stand alone as conclusive indicator of the effectiveness of EFT as a treatment for SA in a wider population. However, it does go some way to building on the existing evidence of the possibility that strands PCE therapy can be an effective treatment for this condition in psychotherapeutic practice. Some tentative conclusions can be drawn around the potential for EFT to be an effective treatment for SA, even though this study had set out to explore factors more closely tied to low therapeutic outcome. It also demonstrates the strength of HSCED as a tool not only for drawing conclusions about the effectiveness of treatment, but for giving due consideration to the range of idiosyncrasies, complexities and contradictions that characterise any single case of therapy. Though results are not strong or clear-cut, they contribute to a developing body of single case evidence that aims not only to develop our understanding of what works for whom, but to offer insight into the processes at work in therapy at a detailed level.

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References

Barkham, M., Evans, C., Margison, F., McGrath, G., Mellor-Clark, J. & Milne, D. (1998). The rationale for developing and implementing core batteries in service settings and psychotherapy outcome research. *Journal of Mental Health, 7*, 35–47.

Bohart, A.C. & Boyd, G. (1997). *Clients' construction of the therapy process: A qualitative analysis.* Paper presented at a meeting of the Society for Psychotherapy Research, Chicago.

Bohart, A.C. & Humphreys, C. (2000, June). *A qualitative 'adjudicational' model for assessing psychotherapy outcome.* Paper presented at a meeting of the Society for Psychotherapy Research, Chicago.

Clark, D.M. & Wells, A. (1995). A cognitive model of social phobia. In R.G. Heimberg, M.R. Liebowitz, D.A. Hope & F.R. Schneier (Eds.), *Social phobia – diagnosis, assessment and treatment.* New York: Guilford.

Connor, K., Davidson, J., Churchill, L., Sherwood, A., Foa, E. & Weisler, R., (2000). Psychometric properties of the social phobia inventory. *British Journal of Psychiatry, 176*, 379–386.

Elliott, R. (2001). Hermeneutic single case efficacy design (HSCED): An overview. In K.J. Schneider, J.F.T. Bugental & J.F. Fraser (Eds.), *Handbook of humanistic psychology.* Thousand Oaks, CA: Sage.

Elliott, R. (2002a). *CSEP-II experiential therapy session form.* Department of Psychology, University of Toledo.

Elliott, R. (2002b). Hermeneutic single case efficacy design. *Psychotherapy Research, 12*, 1–21.

Elliott, R., Greenberg, L.S. & Lieater, G. (2004). Research on experiential psychotherapies. In M.J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behaviour change* (5th ed). New York: Wiley.

Elliott, R., Partyka, R., Wagner, J., Alperin, R. & Dobrenski. R., Messer, S.B., Watson, J.C. & Castonguay, L.G. (2009). An adjudicated Hermeneutic single case efficacy design of experiential therapy for panic/phobia. *Psychotherapy Research, 19*, 543–557.

Elliott, R. & Rodgers, B. (2010). *Person-centred/experiential approaches to social anxiety: Initial outcome results.* Paper presented at a meeting of the World Association for Person-Centred and Experiential Psychotherapy and Counselling, Rome, Italy.

Elliott, R., Slatick, E. & Urman, M. (2001). Qualitative change process research on psychotherapy: Alternative strategies. In J. Frommer & D.L. Rennie (Eds.), *Qualitative psychotherapy research: Methods and methodology.* Lengerich, Germany: Pabst Science Publishers.

Elliott, R., Watson, J., Goldman, R., Greenberg, L.S. (2003). *Learning emotion-focused therapy: The process-experiential approach to change.* Washington, DC: American Psychological Association.

First, M.B., Spitzer, R.L, Gibbon M. & Williams, J.B.W. (2007). *Structured clinical interview for DSM-IV-TR Axis I Disorders, research version, patient edition.* New York: Biometrics Research.

Fishman, D.B. (1999). *The case for a pragmatic psychology.* New York: New York University Press.

Freire, E. (2007). *Development of a psychotherapy outcome measure based on Rogers' theory of therapy change.* Unpublished MSc Thesis. Counselling Unit, University of Strathclyde.

Goldman, R.N., Greenberg, L.S. & Angus, L. (2006). The effects of adding emotion-focused interventions to client-centred relationship conditions in the treatment of depression. *Psychotherapy Research, 16*, 537–549.

Horowitz, L.M., Rosenberg, S.E., Baer, B.A., Ureno, G. & Villasenor, V.S. (1988). Inventory of interpersonal problems: Psychometric properties and clinical applications. *Journal of Consulting and Clinical Psychology, 56*, 885–892.

Hyler, S.E. (2007). *The Personality Diagnostic Questionnaire – 4th Edition (PDQ-4).* Columbus, OH: Human Informatics.

Jacobson, N.S. & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology, 59*, 12–19.

Kazdin, A.E. (1981). Drawing valid inferences from case studies. *Journal of Consulting and Clinical Psychology, 49*, 183–192.

Kessler, R.C., Berglund, P., Demler, O., Jin, R. & Walters, EE. (2005). Lifetime prevalence and age-of-onset distributions of *DSM-IV* disorders in the national comorbidity survey replication. *Archives of General Psychiatry, 62*, 593–602.

Llewelyn, S. (1988). Psychological therapy as viewed by clients and therapists. *British Journal of Clinical Psychology 27*, 223–238.

MacLeod, R., Elliott, R. & Rodgers, B. (2012). Process-experiential/emotion-focused therapy for social anxiety: A hermeneutic single case efficacy design. *Psychotherapy Research, 22*, 67–81.

McLeod, J. (2010). *Case study research in counselling and psychotherapy.* London: Sage.

Miller, R.B. (2004). *Facing human suffering: Psychology and psychotherapy as moral engagement.* Washington, DC: American Psychological Association.

Rogers, C.R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21*, 95–103.

Stephen, S. & Elliott, R. (2011). Developing the adjudicated case study model. *Pragmatic Case Studies in Psychotherapy, 7*, 230–241.

Stephen, S., Elliott, R. & MacLeod (2011). Person-centred therapy with a client experiencing social anxiety difficulties: A hermeneutic single case efficacy design. *Counselling and Psychotherapy Research, 11*, 55–66.

Wagner, J. & Elliott, R. (2001). *The simplified personal questionnaire.* Unpublished manuscript, University of Toledo.

Watson, J.C., Goldman, R.N. & Greenberg, L.S. (2007). *Case studies in emotion-focused treatment of depression: A comparison of good and poor outcome.* Washington DC: American Psychological Association.