Real Clinical Trials (RCT[1]) – Panels of Psychological Inquiry for Transforming Anecdotal Data into Clinical Facts and Validated Judgments: Introduction to a Pilot Test with the Case of "Anna"

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ABSTRACT

This article reports another stage in the development of the Panel of Psychological Inquiry (the "Panel") model for evaluating case-study knowledge claims. Inspired by Bromley's (1986) quasi-judicial model of clinical case studies, the methodology for evaluating clinical case-studies involves seven components: (1) standards of evidence for anecdotal data; (2) participants (judges, advocate, critic, witnesses); (3) pre-hearing review of the written case study and specific advocate claims and critic counterclaims; (4) collecting physical evidence and interviewing potential witnesses related to the case; (5) a sixteen step hearing procedure; (6) the judges' opinion; and (7) appeal. This article begins with a rationale for and background on the Panel model, followed by an introduction to a specific pilot test of it. In the pilot text, a five-member Panel consisting of senior practitioners and academics conducted a five-hour hearing on the treatment of "Anna," an 18-year-old, first year college student with a six year history of anxiety, panic, depression, and persistent self-cutting, who was seen in therapy by a clinical psychology graduate student. The judges evaluated five knowledge claims about the severity of psychopathology; relationship of the symptom to defenses; therapeutic orientation; outcome; and role of counter-transference in the case. This introduction orients readers to five other papers associated with the pilot test: (a) a systematic case study of Anna's treatment (Podetz, 2008, 2011a), which was part of the "physical evidence" of the case and which constituted the author's master's thesis; (2) and (3), the arguments that the advocate and critic (Altman, 2011 and DiGiorgianni, 2011, respectively), presented to the Panel of Inquiry, as well as some comments about their roles and experiences (not discussed at the Inquiry); (4) the experience of the therapist (Podetz, 2011b) in presenting to the Panel of Inquiry; and (5) the findings of the Panel of Inquiry (Miller et al., 2011).

Key words: Panels of Psychological Inquiry, quasi-judicial method, jury hearing, case study, clinical case study

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INTRODUCTION

Over the past decade there has been a renewed interest in the clinical case study as a formal research method. One clear strand of this movement seems to grow out of a dissatisfaction with the clinical utility of conclusions drawn from traditional, empirical, randomized controlled trial (RCT) research studies (Bromley, 1986; Fishman, 1999, 2005; Edwards, 2007; Eells, 2007; Davison & Lazarus, 2007; Elliott, 2002, 2009). In these authors one senses a desire to augment or supplement mainstream research approaches, and recognition of the inevitable limitations of a human experimental methodology that the author's find fundamentally acceptable, if flawed. A second strand of the revitalized case study literature sees the development of case study methodology as an attempt to develop a radically different approach to research in professional, clinical, counseling, and applied psychology in general (Hoshmand, 1992; Miller, 1999, 2004; McLeod, 2002,Bohart, 2008). This group looks to the narrative, hermeneutic, phenomenological, human science, qualitative or quasi-judicial traditions in the philosophy of social science as a means of re-defining what it means to be scientific about clinical knowledge, and what it means to validate facts and theories about clinical practice.

Members of this second group are more inclined to replace the randomized clinical trial with revitalized clinical case study research methods than to offer case studies as supplemental to an RCT design. In so doing, the second strand eschews the pursuit of strictly causal hypotheses and theories as a goal of clinical research. While the second strand seeks generalized knowledge, the generalizations are often in the form of statements of clinical wisdom, concerning ways of relating and being that are difficult to describe in linear or concrete terms. These clinical processes often are defined holistically, combining the concrete and the abstract, the descriptive and the evaluative, the physical and the intuitive reality of the moment. These latter kinds of generalizations about practice have a heuristic element, and can guide clinical practice, but because of the complexity of personality and the uniqueness of every human life, the assumption is that such generalizations, even when validated, must always be implemented in a creative manner in any individual case. The generalizations will be about what can be done to maximize the creative therapeutic process that is critical to success in individual cases, not maximizing success in types or groups of patients. A series of individuals with some similar symptoms are not necessarily a group of essentially similar individuals, and not a meaningful grouping in terms of what exact treatment will ultimately be most helpful (Eells, 2007).

Nonetheless, both strands share many of the same methodological goals concerning how to formalize clinical case study methods to overcome past objections to the case study as highly subjective, biased, and inconclusive in contributing to the development of a knowledge base for the profession that can be applied to new cases and situations. Another very important distinction between the first and second strand of case-study revivalists is that the first strand is primarily interested in integrating case study research into studies that are pre-planned to test specific clinical hypotheses, whereas many of the participants in the second strand are invested in developing a case-study methodology that systematizes and validates the clinical knowledge that grows out of clinical practice as it naturally occurs in clinical settings, much in the manner that case studies were written and published in the first half of the twentieth century (e.g., those of

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Freud, Adler, Jung, though with improvements as mentioned above to answer criticisms of subjectivity and bias). Implicit to this line of argument is the assumption that a great deal of clinical knowledge exists in experiential and practical forms that needs to be culled from the community of practitioners in order to share the wealth with other practitioners and students entering the field, (as well as to guide researchers in where clinical knowledge can be genuinely supplemented).

This clinical knowledge that emerges from practice exists as knowledge *per se*, not as mere opinion, or subjective bias, but is often inchoate, and needs to be made explicit, and shared. A formal case- study is from this perspective the natural extension of an epistemological process that occurs everyday within communities of practitioners. Before we can formalize and improve upon this process we first have to understand it, particularly in clinical settings and communities that are functioning well (Miller, 1998, 2004). Nonetheless, there are controversies among practitioners as well, and the clinical community needs a methodology of its own, true to its own indigenous epistemology, to resolve these disputes without necessarily having to adopt the criteria of the laboratory sciences for what counts as real knowledge.

Participants in the second strand also see considerable benefit of case study research in improving clinical training in two additional ways: (1) advancing the ability of trainees to make clinical formulations, and advocate in clinical settings for their treatment approaches or diagnostic decisions; (2) as an instrument of pedagogy, using case studies in the teaching of clinical theory and technique. Students are much more eager to read case studies than either empirical research studies or highly theoretical papers, and often report a much clearer understanding of clinical concepts and techniques once they have read case- studies related to a theory. All of this relates very closely to Schön's (1987) concepts within his epistemology of practice, and the fundamental difference between applied (or clinical) knowledge, and abstract, theoretical/scientific knowledge that is subjected to empirical validation testing.

While it is true that policy makers have come to expect that statistical data are necessary to evaluate any activity paid for with government funds, the idea that the success of teacher-student or therapist- client relationships can be evaluated using the same research methodology or logic in use in astrophysics or physical chemistry is highly suspect. Every domain of knowledge must develop its own indigenous criteria for making truth claims based upon the nature of the subject matter, the complexity of the phenomena, and the goals of the activity studied. Aristotle (Putnam, 1978) noted long ago that not all subjects admit of the same degree of precision or certainty, and claims must be evaluate against different criteria in different domains of knowledge in order to have the best knowledge possible within each, and not confound one domain with criteria developed for another. The proof of a geometric theorem can be known precisely, logically and with certainty, whereas the best way to cook an egg will be dependent on a variety of situational circumstances that may vary over time, place and persons involved.

Conventional research methods in psychology were developed using biological and agricultural research as a model. These disciplines seek to establish causal explanatory principles

for the purposes of understanding basic life processes. These findings are expected to be generalizable to a wide variety of similar environments, and universal when considering temporal factors. While many in humanistic and psychoanalytic psychology questioned the wisdom of adopting models developed in a disciplines with a very different subject matter, Bromley (1986), an experimental psychologist specializing in cognitive development across the life-span was the first to systematically demonstrate that clinical logic and reasoning were much more closely aligned to legal reasoning than scientific reasoning, and we should look to the legal system as a model for psychological research rather than the scientific laboratory. (Though, Levine (1974) had earlier made a strong argument for the idea that clinical research was more akin to investigative journalism or police work, he had not developed it into a formal research methodology).

The central argument in Bromley's justification of a quasi-judicial approach is that, similar to the practicing attorney, a clinician is trying to find out the truth about the existence and relationship of specific events that have already happened, and that for one couldn't or for ethical reasons wouldn't replicate in a controlled experimental study. Furthermore, one is not interested initially in formulating generalizations about groups of cases, only what would make sense of the present case under scrutiny. In order to make sense of an individual case, one of necessity thinks of basic general propositions about the world, or frequently occurring similar situations (e.g., "people generally become more angry after they have been injured"). However one may also think of another individual case one has encountered in the past that shares a highly idiosyncratic and low base-rate characteristic with the case in question. Once one has determined what has happened in the past, and who or what is responsible for the problem, one must take steps to prevent a recurrence, and repair or rectify the situation. In the law this involves asking the courts/state to intervene to compensate a victim or punish a perpetrator. In psychology reparative work involves an array of interventions that also may alter the contingencies of behavior (though usually in less stark terms), the quality of interpersonal relationships, self-awareness, and personal autonomy.

This integration of investigation into the source of a problem and its remediation in each professional action is rarely seen in experimental research in clinical psychology. There, one investigation may explore causation and another remediation. But in applied fields the exploration of causation is intricately connected to resolving what is to be done next with the situation at hand. Granted what is to be done next is of a different nature in the legal and psychotherapy realms, but in both instances the assessment of what has transpired leads to steps taken to produce changes in the conditions or actions of those involved. The goal is to change the behavior or the nature of the relationship between the parties involved. Civil court judgments may order one party to make restitution to the other, or may leave the parties in the same relationship to one another as before the trial. In either result, each side would have had to sit through and possibly listen to a thorough presentation of the other side's arguments or point of view, something that rarely happens in intense interpersonal conflicts. Each side has had their "day in court' where they can testify before their community and have their voice be heard. Again, this is not a common experience in the everyday world. In these ways, legal and clinical intervention processes overlap: through the use of anecdotal data a rigorous process of

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examining testimony and evidence contributes to a greater understanding of the origin of interpersonal conflicts, and sets the stage for actions taken to ameliorate the situation.

IN PRAISE OF ANECDOTAL DATA

Bert Karon (personal communication, 2005) once said in a lecture that he believed that nearly every important that had been learned about psychotherapy had been learned from listening to what patients tell us about the process, and I think this resonates with the experience of many therapists. Psychotherapy is an interpersonal activity, a social practice, a professional enterprise, or a craft, before it is anything else (a theory, science, or technology). We learn it by doing and reflecting on how we do it (Schön, 1987). Our clients need us to be open to what they have to teach us about what they need and what they have endured, and the field needs us to pass along to one another these lessons in how to do psychotherapy better. The case study is the indispensable vehicle both historically and logically for transmitting that part of clinical knowledge that can be conveyed verbally from one practitioner to another.

It is one of the great ironies of our profession that at a time when there are more people practicing psychotherapy than ever before, we have moved so far away from honoring the writing and publishing of case studies that we have so little record of the clinical knowledge that is being generated today. The waste of intellectual capital is appalling. The one kind of clinical research that is intrinsic to actual clinical practice- the writing about cases that happens in records, assessments, reports to various agencies, etc. - and which with a little refinement could be developed into valuable case studies communicating what is being learned by therapists from their clients, is disparaged by almost everyone as anecdotal data, and dismissed as mere speculation, opinion, or self-serving bias. Meanwhile, these very same critics often disparage clinicians for not doing clinical research, and not reading the clinical research that is being published.

Think about what happens each year at conferences like the APA where thousands of psychologists convene to share evidence of their work. All register for the conference, choose their airline flights from reported schedules, find their way to their hotels and the convention center with reported directions, select their meals from a menu that reports available foods at a restaurant, and even will learn how and in what manner their colleagues conduct their experimental and quantitative research based upon verbal (narrative) accounts of how research was conducted. We live our lives surrounded by a sea of testimony, another name for anecdotal reporting. As the epistemologist Coady (1992) has argued, even *the report* of the most sophisticated data analysis remains an anecdotal report of who did what research, where and when. The statement, "There was a large effect size between the treatment and control groups, and the group means were separated by 1.5 standard deviations" is an anecdotal report. It contains some non- anecdotal data embedded within it, but it remains primarily an anecdotal report. In this instance, before the data can be accepted as worth considering, one has to decide to believe that the researcher did, in fact, split the subjects into two groups, treat one, measured outcome, ran the data, and reported it accurately. Only the actual results, reported in the Results section in a quantitative study is non-anecdotal reporting. The results as reported are an

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anecdotal report of a statistical analysis of quantitative data testing a hypothesis. If it is the case that anecdotal reports are inherently untrustworthy, no one should be able to get papers accepted for the conference, and that is just as well since none of the research reports presented can be trusted.

The problem that I have been ignoring until now, but I am sure the scientific reader hasn't, is that this sea of testimony is at times choppy, polluted, and ill- charted. While we rely on it to live our lives, and usually successfully, at times it lets us down in dramatic and destructive ways. In addition to anecdotal reports that are false or deceptive, we can be thrown by those that are vague, confusing, incomplete, ambiguous, or indeterminate. Similarly, case studies vary tremendously in their format, content and utility. Bromley's (1986) quasi-judicial method of writing case studies has inspired a number of us in the last decade to try to remedy that situation (as in the *PCSP* guidelines), but conceptually the question of how to determine the quality of the evidence required in the case study remains an open one. How do we separate adequate from inadequate evidence that arises in every day practice, mostly in anecdotal form? Bromley tells us that the evidence must be reported honestly, that it must be relevant and consistent, and that we must do diligent research to find the best evidence available. That is a start, but how do we know when it is honest, the best, sufficiently consistent? This is the question that I think lies at the heart of much of the distrust of anecdotal data and the narrative case study.

As discussed in Miller (2004), in some clinical contexts where clinicians work in teams within an open environment where there is good communication between supervisors and staff clinicians, informal peer supervision, frequent case conferences to review ongoing work, and free and respectful communication about difficult cases and clinical work in general, many of the problems that we have evaluating cases in written reports just don't occur. We know how reliable various staff members are, how meticulous their work is, and how honest and realistic their reports tend to be. We have a sense of their clinical style and skill from observing them in interaction with ourselves. We may have clients who talk about the staff member's clients, and run into their clients in the waiting room or take a call from them when we are doing emergency coverage. In other words, the knowledge that emerges about cases in a clinical setting of this kind is already communal knowledge, and has consensual validation integrated into the clinician's judgments and assessment of the case. The question is how to make this consensual validation available to clinicians working in more isolated settings, or more explicit to those outside the clinical community who may question its validity. That is the goal of developing the quasi-judicial model into a formal case hearing process with established rules of evidence

EVIDENCE AND THE LAW

As Bromley (1986) has noted, the Western legal tradition has a 500 year history of developing standards for introducing and evaluating evidence in civil cases that might be seen as providing a model for the more general evaluation of testimonial or anecdotal data in other contexts, including the psychotherapy case study.

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Since 1975, the United States Congress working with a commission headed by then Chief Justice of the Supreme Court Warren Burger, adopted a uniform set of rules, *The Federal Rules of Evidence* (cf., Weissenberger, G. & Duane, 2007) governing all Federal courts, and voluntarily adopted in many of the states' courts as well. (I am indebted to Professor Kenneth Kreiling of the Vermont Law School for directing me to the relevant legal literature, and offering the benefit of his many years of experience teaching the law of evidence.)

The quality of the evidence in a case in civil law is determined by a *general* process of inquiry applied to *specific c*ases, and by established rules derived from experience with different kinds of evidence (particularly hearsay). While we can not import this procedure and these rules into psychology without some modification or interpretation, the parallel social functions of civil law and psychotherapy (conflict resolution and restoration to a position of wholeness) result in a remarkable ease of application.

THE EVIDENTIARY PROCESS FROM THE CIVIL LAW

The Burden of Proof, Notice and Presumption.

First, all evidence is evaluated through an adversary process involving the burden of proof, which means that the side making a claim of harm must first present evidence in support of the claim, and only then must the other side present any evidence at all. If either side fails to present evidence, the judge may issue a *directed verdict* in favor of the side that offered a case, even if a weak one. In most civil cases a claim must be proved by "the preponderance of evidence." In more serious cases, evidence must be "clear and convincing." The more stringent criterion of proof, "beyond a reasonable doubt" is reserved for criminal prosecutions. Particularly with the "preponderance of evidence" standard of proof, we can see how proving one's point in the law is relative to the strength of the alternative position. The truth is in this sense contextualized to both the specific case and the quality of the argument and evidence on each side.

Matters of general or local common knowledge may be entered into the record as true without any evidence at all with *judicial notice*. In other words, in the absence of objection from either side in a case, a judge may accept as established well known general facts without the presentation of evidence. So in a clinical case-study context this might mean that one could state the existence of widely accepted clinical syndromes, diagnoses, generally accepted treatment approaches, or clinical services and institutions without having to provide supporting evidence that such phenomena actually exist in the world of clinical practice. Furthermore, once certain facts are established these facts may create presumptions of the truth of other facts. The classic example in the law is that when there are multiple occupants in a moving car, and it is unclear who is the driver, the occupant who is the owner of the car is presumed to also be the driver unless proven otherwise. (An example of how presumptions might apply in clinical case- studies might be that once having described a client as exhibiting the typical negative symptoms of schizophrenia, one might presume such a person would have limited employment options, and to

have experienced the effects of stigmatization as a result of the diagnosis being in her/his medical file, or known to others in the community).

The concepts of *notice* and *presumption* speak to the laws concern with the burden of proof. Where should the burden of proof fall if we were to adopt his model for researching psychotherapy? In the civil law, the party asserting that an injury has occurred and asking for reparations must prove that the defendant was responsible for the injury, the extent of the damages that must be compensated, and the remedy that is sought. Initially, it is the client and clinician who share this burden of proof in psychotherapy. During an initial assessment period, client and therapist attempt to reach a common understanding as to both the nature and extent of the problem (the harm) and a suitable treatment plan (or remedy). In turn, should the therapist choose to write a case-study on the work with the client, then the therapist has the burden of proof to show that this client did indeed have a problem that warranted the treatment that was provided, and a further burden of proof as to the outcome of such treatment.

One benefit of adopting the case law model from the civil courts is the recognition in that system that case law reflects the perceptions, understanding and moral sensibilities of the community where the case is tried, and that in different locales, those perceptions and sensibilities may be quite disparate. Often the legal system is content to have different outcomes in different locales, and an effort to standardize rulings and findings would place an intolerable burden on judges and courts. The universal applicability of a judicial ruling is only one of a number of competing goals, and is at times seen as counter-productive, ignoring the idiosyncratic meanings of behaviors in different locales. A tolerance of diverse perspectives on social practices is expected, and not seen as a sign of the invalidity of the law. Still, there are times that the courts want to see certain problems similarly addressed throughout the country. Perhaps psychology needs its own arbiter (or Supreme Court) to resolve highly contested diagnoses or treatments, such as Aspergers syndrome, hypnotic treatment of repressed memories, or the use of anti-psychotic drugs with four year olds. One could imagine a system of local, state-wide, regional, and national psychology tribunals (what I call in a later section, Panels of Inquiry) that could operate in this realm. The burden of proof would operate such that those making controversial claims take on the burden of proof. Of course, we don't always agree in psychology as to what to consider "controversial." However we decide as a field to assign the burden of proof on any given question, the critical importance of giving one side the burden of proof must be accepted. Without a starting place for the burden of proof the notion of the adequacy of evidence in testimonial reports is completely indeterminate. That is exactly why the courts exist, to decide what in fact happened, and then what is to be done about it. One can say that a court finds the facts, or creates the facts through its rules and procedures. Regardless of how one interprets the process, without such a process, the truthful answer to certain important questions will remain indeterminate in any given community.

Determination of Truthfulness.

In the law, to establish a fact with testimony (anecdotal evidence) one must satisfy three criteria. First, the witness must have *direct personal knowledge of the problem at hand.* Second,

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the witness must testify under oath. Third, the witness must testify in the presence others who can observe the quality of the testimony offered, and must be willing to undergo cross-examination.

Here the psychotherapy case-study context is almost exactly parallel. The client of course has personal knowledge of her/his problem. The instructions on how to cooperate with therapy often include a commitment to be open and honest, and therapists routinely make inquiries and ask for clarifications that are a kinder, gentler version of cross-examination. Peer review of the therapists' report of the case has similar features. The therapists' professional ethics demand honesty, and clearly the therapist has personal knowledge of the case. The supervision received on the case, or later peer review for publication, both can be seen as logically equivalent to cross-examination. The big difference between the legal and clinical context seems to be in the potentially more public nature of the attempt to resolve legal conflicts and the private nature of the therapeutic attempts to solve interpersonal and psychological conflicts. This difference is no small matter, and invites a great deal of mistrust of clinical knowledge claims by the scientific community. The Panel of Inquiry methodology to be introduced in a later section specifically addresses this shortcoming in clinical knowledge processes.

Hearsay and Exceptions to the Hearsay Rule

Hearsay is when one quotes (in one's own testimony as a witness) another person making a statement that is relevant to the facts being debated, and that quoted statement is being offered as proof of the facts contained in the quotation. Since this person being quoted is not present to be cross-examined, and since we can't be sure the quotation is accurate or factual, the courts exclude hearsay testimony because its truthfulness is suspect, and jurors are presumed to be easily confused or swayed by such reports. In trials before a judge without a jury present, the rules of hearsay are greatly relaxed.

The criticism that case- studies are riddled with hearsay is widely held in the psychological research community. On the face of it, it looks as though a therapist quoting a client's account of her/his life, symptoms, statements to the therapist about therapy, and so forth would all be hearsay since the therapist is quoting the client and the client hasn't taken an oath before a judge, and isn't present to be cross-examined. In fact, much of what clinicians quote their clients saying about their own lives, if presented in a civil court of law in the United States would not be considered hearsay at all, but would fall under the exceptions to the hearsay rules in the *Federal Rules of Evidence*. In a civil court these statements would be admissible as evidence. Of course once admitted in to evidence, such statements might be rebutted by the other side, but they are considered sufficiently credible or useful to be entered into the official proceedings of the court. Here are the criteria set by the *Federal Rules of Evidence* (Weissenberger& Duane, 2007) for evaluating testimony which show the context within which a concern over hearsay arises, and what circumstances are considered in deciding whether to count a statement as hearsay:

1. A witness to be competent must have personal knowledge and swear an oath of truthfulness.

2. Experts must establish their credentials before the judge in order to testify as an expert witness.

3. Hearsay (out-of- court statements to establish matters of fact of relevance to the case) is prohibited. Witness to facts must make statements under oath and be available for cross-examination and observation while testifying. Hearsay is restricted because its truthfulness is suspect.

4. Reports (testimony) by one person of what a second person (not present to be cross-examined) said are admissible when the statements attributed to the second person fit the following categories of verbalizations:

    a. Words that are acts in themselves (e.g., abusive language)

    b. Prior admissions of wrong doing by a party to the case

    c. Present sense impressions

    d. Excited utterances

    e. Reports of statements made to a physician in seeking care

    f. States of mind

    g. Family records

    h. Reputation to prove character, family history, community history

    i. When a person is unavailable to testify, refuses to testify, or is dead and their prior utterances are directly relevant to the facts of the case, statements that would usually be seen as hearsay are permitted.

    j. A statement against one's own financial or penal interests is permitted as it is most unlikely that people would lie in order to harm themselves.

5. Witnesses and evidence may be impeached for: inconsistency; biased-motives to misrepresent; prior dishonest acts; reputation for dishonesty.

6. Examiner may be impeached for: Improper questioning including leading, argumentative, irrelevant, speculative, harassing and hearsay questions.

It is clear from these rules and criteria that when applied to clinical cases it is necessary for a therapist writing a case study to establish her/his credibility (honesty), objectivity, and reputation for same. Critics of a case must also be careful to avoid questions that seem biased, distracting, overly aggressive, or in other ways likely to derail rational argument. There is a sense here that the search for the truth can be derailed by overly emotional or rhetorical arguments.

Further one must note that when considering the application of this model to a therapeutic case study in psychology, the therapist's narrative about the case is the primary testimony. In addition to reporting what the client said (which may or may not give rise to the accusation of hearsay), the therapist is also giving testimony about her/his observations of, and experiences with, the client. This may include the therapist's thoughts, feelings, intentions, therapeutic philosophy, and so forth, as well as observations of the client's specific actions and interactional style.

The therapist may be testifying about factual matters or giving clinical judgments in which case the therapist is more in the role of what the court would call an *expert witness.* When simply describing the clients' actions and statements, the therapist would in a court of law be acting as a simple witness. Notice that in these matters the therapist is reporting his or her own direct experience and so hearsay is not an issue. When the therapist is reporting *what the client said* many of the hearsay exceptions would apply: excited utterance, states of mind, statement to physician seeking care, reputation and family history for reports of family events and dynamics, client statements against one's own interests in terms of admissions of problems and self-destructive patterns. It is clear that, contrary to popular misconceptions in our field, few of the statements that therapists typically attribute to their clients in case-study reports would be considered hearsay were the clinician testifying in a court of law.

However, when interpreting the client's statements and the facts of the case in terms of diagnosis, prognosis, optimal treatment plan, and so forth, then the therapist is taking on a role akin to that of an expert witness in the law. As such the case- study should establish the expertise of the therapist before proceeding. We can not cross-examine each others' clients, so much of the criticism of the evidence in a case must come from the lack of credibility of the therapist, lack of evidence supporting the claim to be an expert witness, other deficiencies in the nature and consistency of the evidence or logic of the argument in the report. Asking for reports from other involved professionals, supervisors, referral sources, school records might be another way to lend credibility without being too intrusive. This is commonly done in clinical practice, and may be referred to in the therapist's account of the case. When quoted directly, it is akin to the introduction of physical evidence in a civil court.

Coady (1992) also discusses the cohesion and coherence of testimony as criteria of evaluation in all types of testimony. *Cohesion* refers to the elements of a case "hanging together," an internal consistency or validity. To be cohesive a case must also be comprehensive and detailed, otherwise one cannot make an adequate judgment as to the cohesiveness of the case.*Coherence* is when the narrative of a case resonates with our more general understanding of how human beings behave, or more specifically, clinical reality as we know it based upon similar cases under similar circumstances. Discussing a series of similar cases treated in a similar manner that all had negative outcomes would be a refutation of the credibility of the evidence or argument in a case under review that had reported a positive outcome, as this would demonstrate a lack of coherence with clinical reality. (See Miller [2004] for a more detailed account of Coady's view on testimony.)

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PANELS OF PSYCHOLOGICAL INQUIRY

Beginning in 1999, and again in my 2004 book *Facing Human Suffering*, I have called for the expansion of Bromley's quasi-judicial approach to conducting, writing, and evaluating case studies to include a formal, live, peer review hearing of a case before a panel of psychologists sitting as judges, or what I call a "Panel of Psychological Inquiry." (Bohart [2005] and Elliott [2002, 2009] have developed similar models for qualitative research.) These panels would adjudicate the validity of case claims that challenge accepted practices or research findings, attempt to resolve controversies in the existing clinical literature in the field, or report new clinical discoveries or techniques. This method would supplement existing peer review methods of evaluating cases for publication, as in *Pragmatic Case Studies in Psychotherapy.*

Unlike every clinician's worst fear scenario of a trial for malpractice, this is not a hearing to determine that a client was harmed by the irresponsible actions of a therapist, but rather a hearing to evaluate a claim that a problem in living (i.e., harm) experienced by a client prior to entering psychotherapy was ameliorated or solved as the result of a responsible intervention of a therapist. While somewhat adversarial in design, the participants including the judges are primarily psychologists, and the goal is not to commend or critique a person, but rather to commend or critique the usefulness of a particular professional practice or practices in resolving a clinical problem. One might think of it as one part thesis defense, one part collegial conference panel, and one part common law legal proceeding. Panels of Inquiry would expedite the development of what Bromley (1986) initially envisioned, a 'common law" of clinical practice in which the laws of practice will emerge over time through the examination of hundreds, perhaps even thousands, of clinical cases in different clinical practice communities, locales, and even countries. In England, and many other English-speaking countries the law of torts and contracts have evolved essentially through the development of common law in this manner. Certainly, if as a society we can develop rules of law for determining the nature and extent of injuries that one person inflicts on another, we can equally well develop rules in psychology for determining the nature and extent of benefit that one person can offer another.

As in the law, actual trials are extremely time consuming and expensive in terms of professional time. As a result, it is estimated that far less than one percent of lawsuits filed with the court actually ever go to trial, but instead are either dropped or settled out of court. Nevertheless, the existence of the trial option and the decisions of prior cases that have gone to trial, greatly influence the resolution of all of the cases or potential cases in the legal system. Cases on which there are opinions set the standards of evidence and logic for evaluating future conflicts, and guide lawyers in advising clients on the likely outcomes of their case.

Similarly, were we to develop a system of Panels of Inquiry for clinical/professional psychology, cases that receive a full hearing before a panel of clinical judges resulting in a published decision would guide clinicians in their everyday case formulations, clinical reasoning, and treatment planning with future clients, and in how to write-up case studies in such a manner as to be accepted by the profession. The published decisions of the Panels of Inquiry would set standards of evidence and reasoning for use in future published cases as well as future panels.

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The remainder of this paper will describe the development and implementation of a formal methodology for the Panel of Psychological Inquiry research model.

Method

The Panel of Psychological Inquiry method can be divided into six components: Participants, Pre-Hearing Procedure, Physical Evidence, Hearing Procedure, and Judges Opinion. and Appeal. (The implementation of an Appeal procedure will not be discussed here.)

The Participants.

Judges. Seven distinguished members of the clinical/counseling psychology academic and practice community known to have an interest in outpatient psychotherapy or college counseling services were invited to serve as judges on the panel. None had fewer than 25 years of professional experience relevant to the case in question. Persons were invited based upon their stature in the profession as well as their reputations as independent thinkers, known interest in psychotherapy, and my sense that they would be impartial and fair representatives of the professional psychology community in Vermont. Despite the absence of any offer of compensation, four of the seven clinical professionals invited readily agreed to participate in the five-hour proceeding. Two of the psychologists (Melvin Miller, Ph.D. and Mark Kessler, Ph.D.) were senior members in university departments of psychology involved in clinical training, and the other two (Marion Bauer, M.Ed.; Sandra Howell, M.A.,and were senior members of the practitioner community with many years of leadership activity in the State psychological association (one as a president, and one as chairperson of the ethics committee). The fifth judge, Kenneth Kreiling, LLB, professor of law at the Vermont Law School had over 30 years experience teaching civil procedure and the law of evidence.

In the future, it might be advisable to have the state psychological association appoint the judges from a list of those with appropriate experience and interest. The judges were all given "Chapter Six, Demonstrating Clinical Knowledge in the Case Study" from *Facing Human Suffering* (2004), which includes a general discussion of how and why a Panel of Psychological Inquiry might be conducted; a brief description of how the actual day of the hearing would be organized and the tasks they would be asked to complete (Appendix A); and closer to the day of the hearing, a more detailed discussion of their task (Appendix B).

The Case Advocate. The advocate presents the case to the panel on behalf of the case-study author/therapist. Like a lawyer representing the plaintiff in a civil trial, the advocate has the responsibility to help her/his client (author/therapist) present the best evidence and arguments in support of the key central claims made in the original case- study write-up. The advocate has access to the written case study, and to the author/therapist, and they work together to sharpen the statement of claims and produce evidence for the Panel to examine, some of which may be referred to in the case study, but not physically included in it. The burden of proof falls on the advocate. Unless, a case is made that important clinical work has been accomplished, the judges will find the claims unacceptable, even if the critic remains silent. The advocate will decide whom to call as witnesses (though generally for reasons of privacy and concern for negative

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therapeutic effects this will not include the client/patient). The advocate selected for the case study of Anna, Ms. Alexandra Altman, was an outstanding second year student in our Graduate Program in Clinical Psychology who had shown herself in classes with the author to be highly articulate, broadly educated, and clinically insightful. She was selected in consultation with the author of the case study as it was important that the author be able to work effectively with the advocate.

In addition, the author met separately on two occasions with both the advocate and the critic (see below) to (1) recruit their participation in the project, (2) to discuss how to develop their arguments about the case, and (3) to review the actual order of events for the day of the Panel hearing. Since in any case- study there are tens if not hundreds of individual claims about matters of fact and patterns of facts (theories), I encouraged both the advocate and critic to keep this first run-through of a Panel of Inquiry focused on one example of each of the following four types of claims: (1) a statement about the nature of the clients problem and its severity; (2) a claim about the nature of the psychotherapy offered; (3) a claim as to the effectiveness of the therapy; and (4) an etiological claim about the source of the client's symptoms. Throughout the six weeks of preparation for the Panel meeting, I conferred by email or phone with both the advocate and critic on a number of occasions to clarify questions that arose about their roles, and to clarify the schedule (see below).

I have suggested elsewhere (Miller, 1999, 2004) that the case-study advocate or critic might be a new role for clinically-oriented academic psychologists who could bring to a case not only clinical awareness, but relevant scholarship from the case-study literature (emerging case law in psychology), as well as supportive theories and qualitative or quantitative studies from areas of the research literature relevant to the case. I encouraged both the advocate and critic to bolster their arguments about the case (where needed) with references to such literature. This was expedited by the use of extensive theoretical and empirical literature in the original written case- study by Podetz, (2008).

The Case Critic. The critic's role is to raise questions about the quality of the evidence and argument in the advocate's presentation of the case claims. While it is inevitably from its inception an adversarial role, all participants in a Panel of Inquiry including the case critic are encouraged to view each other as colleagues jointly interested in developing the knowledge base of the profession. In fact, it is likely that some or all of the participants in any Panel will be members of the same practice community, and actually be colleagues in the full sense of the word. The critic, Dr. Jess DiGiorgianni, was also a second year graduate student in our clinical program. In class he distinguished himself as an incisive thinker, with keen analytical and critical ability. (Perhaps his confidence stemmed from having earned an MA in philosophy and a PhD in neuroscience prior to joining our program.) Dr. DiGiorgianni had been in many classes with both Ms. Altman and Ms. Podetz, the therapist, and there was mutual respect for each other's talents and abilities. There is no question that the critic's role by its very nature generates performance anxiety in the other participants, and for the critic some anxiety about being perceived as negative or judgmental of one's peers. This is probably amplified by their status as graduate students performing their roles at the request of the program director, but it seems likely that it

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would occur among licensed professional colleagues as well. The case study author, advocate and critic each have a paper in this issue of *PCSP* which can be consulted for further discussion of these roles.

Witnesses. The advocate and critic considered calling a number of witnesses to testify at the hearing. The therapist, her supervisor, the college nurse, another graduate intern who had briefly worked with the client, and a local expert on DBT were all entertained as witnesses. Due to time constraints, only the therapist and the clinical supervisor were actually asked to be witnesses before the Panel of Inquiry. Adding the other witnesses would have lengthened the Panel meeting by several hours, and it was deemed by the advocate that their absence would not seriously jeopardize the argument that she was presenting to the Panel.

Pre-Hearing Procedure

Submission of the Case Study

Prior to convening a Panel of Inquiry, representatives of the Panel must first determine whether a written case study raises a sufficiently important theoretical or applied clinical issue to warrant further investigation. If accepted for a hearing by the Panel, the case-study is then sent to all of the judges, the potential advocate and critic to obtain their cooperation in the process. It is important that none have a conflict of interest regarding the therapist/author or the client, and believe themselves competent to argue or judge the questions at issue. In this instance, the case study was that of "Anna," an 18 year old first year college student with a six year history of anxiety, depression and self-harm. It was a 70- page case study written in APA style, with 20 references to the clinical and empirical literature on patient self-harm and cutting. The case study was written as a master's thesis by Ms. Stacy Podetz (2008, 2011a), and had also been reviewed by the thesis advisor prior to submission to the judges. The case was chosen as a good case for demonstrating the methodology, but lacked the kind of highly controversial clinical questions likely to be associated with cases that go to a Panel in the future. (This is not to say that the case was in any sense mundane, or lacking in important clinical insights and information.) The thesis advisor was not on the panel, though he did attend the hearing as an observer.

Advocate and Therapist Develop the Claims

After reviewing the case, the advocate met with the therapist/author, formulated a set of four claims and identified the specific evidence that was available to support those claims. The advocate also interviewed the clinical supervisor and it was decided to call her as a witness. The advocate's position was outlined in a two- page document that was provided to the case critic several weeks before the hearing.

Critic's Answer to Claims

The critic had access to the full case study six weeks prior to the Panel of Psychological Inquiry hearing. After receiving the advocate's position outline, the critic had one week to provide a written response to the advocate's claims, evidence, and logic. In addition, the critic

was required at this point to identify any counterclaims he intended to make, and the evidence he would offer in support of these counterclaims. In the process of preparing his responses, the critic was free to interview the advocate's witnesses (the therapist and the supervisor), or choose other witnesses prior to the hearing. The advocate's written outline, with the critic's response inserted in bold, are presented in Appendix C. This document was provided to the judges after the hearing, but in the future will be sent to the judges prior to the hearing.

Hearing Format and Schedule

All participants were provided with a schedule for the hearing that specified the order and length of presentations by the advocate and critic and the periods of questioning by the judges (see below).

Physical Evidence

Based upon the written case study narrative and discussions with the therapist, the case advocate developed a set of physical exhibits related to the case that could be reviewed by the judges at the hearing. These included the following:

a. The written case study, including two consent forms (see Podetz, 2008, 2011a).

b. The "Client Request for Services Form" from the college counseling center.

c. The supervisor, Andrea Kelley's *curriculum vitae*.

d. The client's creative writing sample.

Hearing Schedule

The Case of "Anna"
May 13, 2008
Procedure and Schedule for the Hearing

9:00 am. Chair of the Panel: Introductions of participants and relevant APA Ethics Code principles that require the honest reporting of data, and responsible handling of clinical information to protect the privacy and confidentiality of clients.

9:10 am. Opening Arguments: *Opening argument by the case advocate* who presented the basic claims being made about the case and outlining the evidence that will be presented (10 minutes). The four claims put forward by the case advocate were as follows:

- Claim One. Without reservation, it is absolutely clear that the patient, "Anna", presented with a serious psychopathology.

- Claim Two. It is clear that Stacy, the therapist, provided humanistic, psychodynamically informed therapy to "Anna".

- Claim Three. This case demonstrates the capacity of a first year intern to be demonstrably useful in providing therapy to clients in a counseling center, as we maintain that it is highly probable that the treatment resulted in increased health and growth.

- Claim Four. Stacy's interpretation that "Anna's" cutting served a self-regulatory function as it offered relief from the tension of both numbness and excessive anxiety, was valid and critical to the client's eventual growth.

Opening argument by the case critic who presented perceived weaknesses in the claims being made about the case by the advocate. (10 minutes)

- Example: I would like to investigate the question of whether the counter-transference at work in the therapeutic relationship negatively impacted the course of the therapy.

9:30: Questioning of the Therapist to Establish Case Claims:

- Advocate questioned the therapist to establish the evidence for the claims being made about the case. (30 minutes)

- The case critic questioned the therapist by (20 minutes)

- Follow-up questions to the therapist by the case advocate (10 minutes)

- Panel members question the therapist/advocate/critic (20 minutes)

10:50 Break

11:00 Questioning of the Supervisor to Establish Claims

- The case advocate questions the supervisor by (25 minutes)

- The case critic questions the supervisor by (15 minutes)

- The advocate asks follow-up questions of the supervisor by (10 minutes)

- Panel questions the supervisor/advocate/critic (20 minutes)

12:10- 12:40 pm Lunch break

12:45 Questioning of Therapist to Establish Counter-Claims

- Case critic questions therapist on counter-claims (25 minutes)

- Case Advocate questions therapist (20 minutes)

- Follow-up questions by case critic (10 minutes)
- Panel questions the therapist/advocate/critic (10 minutes)

1:50 Closing Case Summaries

- Case Advocate (10 minutes)
- Case Critic (10 minutes)

Judges' Opinion

The judges were provided with a form (Appendix D) for evaluating both the advocates' and critic's presentations by considering (1) how a claim was stated, (2) the evidence, and the quality of the evidence that had been provided in support of that specific claim, and (3) the specific rebuttal of that claim that had been offered by the other side. After each claim, the judges were asked to state specifically whether they accepted or rejected the claim and why. The results were synthesized and summarized by the author, and returned to the judges for their final editing. The Panel's findings in the case are presented in a separate paper (Miller, Kessler, Kreiling, Miller, Bauer, and Howell, 2011). It is anticipated that Panels would regularly publish their findings, and that this would be a formal mechanism for charting the growth of case-law in the field of clinical and professional psychology.

Appeals

It is anticipated that Panels of Inquiry might be established for specific states by state psychological societies or universities, and over time higher level Panels might be sponsored on a regional basis by various professional organizations that would allow cases to be appealed when the advocate or critic believes that a Panel's findings were misguided or unfair to the participants. This would be a vehicle for generalizing case law at a broader level within the profession of psychology particularly when controversial clinical issues have regional or national importance. One thinks of the current controversy over the involvement of clinical psychologists as advisers to military interrogations as an issue that could not be investigated empirically for obvious ethical reasons, but might be tried before a Panel of Inquiry to determine whether the advisers had in fact provided benefit (as claimed) to those interrogated. Similarly, during the controversy a decade ago about therapies that sought access to repressed memories, the availability of Panels of Inquiry might have gone far to resolve the contradictory claims of clinicians and experimental social psychologists.

AREAS REQUIRING FURTHER DEVELOPMENT

While the Panel of Inquiry exceeded our expectations for creating a formal community of persons of diverse professional and theoretical backgrounds focused on evaluating the knowledge claims of a specific clinical case-study, it was not without drawbacks. Chief among these was surely the amount of time and energy invested by the judges, advocate and critic in a

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case which was not their own. It is clear that a full-scale formal hearing that evaluated all of the important claims in a case would probably be a far more complex undertaking. All participants generously donated their time to this demonstration project. In the future, for this process to be implemented a funding source will need to be secured. Considering the senior status in the profession required to be a credible judge, and faculty status anticipated for the advocate or critic, it is estimated that each full Panel of Inquiry might cost fifteen- thousand dollars of professional time (excluding that of the author of the case study). Considering the cost of many empirical research projects this is not an exorbitant amount, but nevertheless would require foundation or government agency funding.

Secondly, the role of critic has been a more difficult one to design and execute than we anticipated. Criticizing a colleague's therapeutic work in a public forum is often not an easy task to perform, and we vacillated between a highly adversarial conceptualization of the role and a more congenial and supportive one. What we strove for was intellectually honest criticism, involving a willingness to praise strengths as well as criticize weaknesses of the case-study. The members of the panel were quite divided in their view of how the critic's role was conceptualized in this particular implementation of the model, several preferring an approach that would have been more aggressively adversarial.

The issue of confidentiality and therapeutic impact of the hearing remains vexing. The central witness in a tort trial is often the injured party, and by extension the central witness in a case study Panel of Inquiry hearing would logically be the client. However it is unlikely that many therapists would or should risk the potential disruption of the therapeutic relationship or potential harm to the client that would result from appearing before a Panel or observing the whole hearing. Perhaps it will be possible to elicit the client's testimony in a written reflection on the written case study, or a videotaped interview of the client conducted by the advocate paralleling the depositions used in the legal system. The therapist in this case thought that asking the client to participate in any way in this hearing was too risky given the client's current functioning and history of having been used by her father (a teacher) as an example before his classes.

CONCLUSION

As a report of the first full-scale implementation of the Panel of Inquiry model of case-study research, this paper demonstrates the logic and procedures for demonstrating how clinical knowledge claims can be further validated by a wider clinical community or the profession at large. The Panel of Inquiry is a real clinical trial (RCT[1]) for it allows us to validate our clinical facts and theories of practice without distorting those practices through the lens of a research protocol designed for answering questions of linear causality in the physical sciences. The Panel of Inquiry brings representatives of the practice community in a specific locale together to evaluate the clinical knowledge claims made by local practitioners. Over time, it is anticipated that as with the common law, such local knowledge claims will aggregate and provide a broad scale consensus on effective clinical practices that may be eventually be validated at regional or national level Panels of Inquiry. It is a ground-up approach to knowledge generation and

validation, and demonstrates that with rigorous attention to evidence and logic anecdotal evidence is not inherently inadequate as a basis for developing our knowledge of clinical problems and treatments.

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Note: After the Panel of Inquiry described in Miller (2011) was completed, Podetz's masters thesis was reformatted and copyedited to meet the guidelines of a *PCSP* case study, and some of the broader literature review was shortened. Aside from these two differences, the substance of Podetz's 2008 and 2011a versions of the case study of Anna are identical.

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APPENDIX A: INTRODUCTION TO THE DAY OF THE HEARING

Dear Panelists:

I am happy to report that due to the cooperativeness of all involved we have been able to agree on Tuesday, May 13th, 9:00 am- 2:00 pm as the meeting date and time for the panel of Psychological Inquiry.

A hard copy of the case study that will be examined by the Panel went out in the mail today. If you also would like to have a pdf file of the case I would be happy to have one sent as well.

There is one additional point which I should perhaps emphasize as you are about to read the case. This Panel will serve as the equivalent of a pilot study in the development of a methodology for evaluating the truth claims from a clinical case study. It is my expectation that if the development of this method is successful it will be used to evaluate claims made by clinical practitioners about the effectiveness of their work or the source of their clients' difficulties. Given the time, energy and exposure required by such an elaborate form of peer review, it would be unlikely for a case to be brought before a panel unless it made a controversial claim, challenged accepted practice or belief, or demonstrated an innovative approach or conceptualization of a problem.

However, for this pilot study, the case to be evaluated was not held to such a high standard. I chose a case based upon a student's willingness to have their master's thesis subjected to this kind of rigorous critique, the face validity of her description of the case to me, and her reputation as a reliable, responsible student who would complete the rough draft on schedule. I believe the methodological issues inherent in evaluating a clinical case study are by and large similar regardless of the novelty or controversy associated with the case, and so the pilot study will be highly informative despite this difference.

There is a chapter in my book *Facing Human Suffering* on the case study as a means of capturing and communicating clinical knowledge which I will be sending out to each of you that you may find useful. It sets out a conceptual framework for thinking about cases in a quasi-judicial manner relying on Bromley's work on that topic (that in turn is based upon the philosopher Stephin Toulmin's work on rhetoric and informal reasoning). The chapter discusses standards for the content of a comprehensive case study, the logic of argumentation in a case, and the quality of evidence used in support of the argument. Bromley himself did not envision actually holding an adversarial hearing on a clinical case, and so that is where we are breaking new ground with this pilot study.

Unlike the case itself, it is not necessary that you read the chapter. It is there if you wish more concrete context for the panel. Ultimately, I will be asking for you to exercise your seasoned clinical judgement as to whether you were most persuaded by the therapist and her advocate, or alternatively by their adversary, the case critic, on the specific claims about the case put forward to the panel.

Thank you all again for your interest in the project and your cooperation in setting the date of May 13.

Best,

Ron

APPENDIX B: DETAILS ABOUT THE DAY OF THE HEARING

Memo to Panel of Inquiry Members

Ron Miller

May 8, 2008

Several of you have asked me exactly what you will be asked to do as judges on the Panel of Inquiry. What follows is an attempt to provide a provisional answer to that question in as succinct a manner as possible in anticipation of Tuesday's meeting. But first, one general disclaimer: As we proceed with this pilot project, I expect that one of the things that will happen is that the participants will develop creative ideas on how the process can be improved and the roles more clearly defined. So the description below is truly provisional.

I see this Panel as attempting to augment the kind of inquiry that might be engaged in by colleagues at a professional meeting discussing different perspectives on the same clinical case by adding features of fact finding and decision making used in our civil court system. In cases of personal injury or tort law, of which clinical malpractice is but one of many types, a judge/jury is asked to decide what events transpired, was anyone seriously harmed, and who is responsible for that harm occurring.

If we change the notion of harm to one of benefit, why shouldn't many of the same procedures be useful in determining what happened between a client and therapist, has the client benefited, and is the therapist responsible for the benefit that occurred. The courts assume that in determining injury, and responsibility for that injury, average citizens acting as a jury of peers can evaluate such claims wisely.

As experienced clinicians, I believe that you are in a better position to make those judgments than persons unfamiliar with the process of psychological treatment. Nevertheless, since the claims have many of the same features as those in a personal injury claim (again, with "benefit' replacing "injury"), I believe that you as a group are capable of deciding on the truth of such claims using some combination of ordinary human reason and clinical knowledge. You may also have to decide whether the clinical evidence and judgment of the therapist and her supervisor are sufficient, or whether you would only be convinced by the presence of empirically validated psychological claims.

The Panel will be asked to decide questions of fact. Some of these questions will be rather basic factual questions such as, "Was the client, Anna, a "cutter?" A more difficult questions of fact might be, "Did Anna's cutting diminish over the course of the two semesters of psychotherapy?"

The Panel may also be asked to decide questions of the interpretation of the facts, for example, "Did Anna cut herself to maintain a sense of control over her own pain?" Or, "Did the

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therapist fail to adequately explore the role of the mother-daughter relationship in the origins of her symptoms?"

There are also potential questions of a moral nature, " Was the therapist compassionate, caring, and respectful of her client?" Is the client's life going in a better direction as a result of the therapy, has she truly benefited from the work?"

Since there are probably tens, if not hundreds, of potential claims contained in the case narrative you have received, and our meeting is limited in time, I have asked the case advocate and critic to limit the discussion to only a handful of claims and counter-claims, with the supporting evidence and arguments. These will be identified for you in their opening arguments, and while the entire case narrative can be used by you in evaluating these more limited claims, *you will only be asked to make a decision on the specific claims that are presented to the Panel on Tuesday.* (I don't know exactly what these are at this time.)

In terms of procedure, here is how I currently anticipate the Panel of Inquiry will be conducted. You will note that at three points in the process the Panel will have time to directly question the advocate, critic or the witnesses (i.e., the therapist or supervisor). I will serve as the Panel administrator, attempting to keep people on schedule, and deal with any procedural difficulties. My goal is to avoid a highly adversarial procedure, and to preserve a collegial sense of disciplined inquiry.

9:00 am: **Opening Arguments:**

1. Opening argument by the case advocate presenting the basic claims being made about the case and the outlining the evidence that will be presented. (10 minutes)

2. Opening argument by the case critic presenting perceived weaknesses in the claims being made about the case by the advocate. (10 minutes)

9:25: **Questioning of the Therapist to Establish Case Claims**

3. Questioning of the therapist by the advocate to establish the evidence for the claims being made about the case. (30 minutes)

4. Questioning of the therapist by the case critic (20 minutes)

5. Follow-up questions to the therapist by the case advocate (10 minutes)

6. Panel's questions of the therapist (20 minutes)

11:00: **Questioning of the Supervisor to Establish Claims**

7. Questioning of the supervisor by the case advocate (25 minutes)

8. Questioning of the supervisor by the case critic (15 minutes)

9. Follow-up questions to the supervisor by the advocate (10 minutes)

10. Panel's Questioning of the supervisor (20 minutes)

12:00- 12:30 pm: **Salad Buffet Lunch Served at the International Commons**

12:35: **Questioning of Therapist to Establish Counter- Claims**

11. Questioning of the therapist by the case critic

    to establish counter- claims. (25 minutes)

12. Questioning of therapist by case advocate (20 minutes)

13. Follow-up questions by case critic (10 minutes)

14. Panel's questioning of the therapist (10 minutes)

1:40: **Closing Case Summaries**

15. Case Advocate (10 minutes)

16. Case Critic (10 minutes)

At the conclusion of the Panel of Inquiry I will be asking for the judges to deliberate over the course of the next week and then provide me with written feedback on the case and the process. I will provide a feedback form to minimize the time required to respond. You will be asked for each claim whether you think it was proved by a "preponderance of the evidence" (not the criminal law criteria of "beyond a reasonable doubt.")

I will synthesize the feedback and write a summary of the panel's findings, which I will circulate to you for your editorial comments. We will try to reach a consensus opinion for the panel's findings, but if we can't, we may have to vote on a split decision, with the possibility of a minority as well as majority opinion. I will be happy to write both, if need be.

Since this is a pilot project the actual decision is much less important than discovering how the different aspects of the process work. I will try to keep your time investment to a minimum, post May 13th.

Finally, as I have mentioned before, I will be presenting a summary of the proceedings and the findings to a symposium on adjudicating case studies to the Society of Psychotherapy Research meeting in Barcelona, Spain, in mid- June, and will be crediting all of you as co-authors on the paper.

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APPENDIX C: THE ADVOCATE'S CASE OUTLINE FOR THE PANEL JUDGES WITH THE CRITIC'S RESPONSES INSERTED IN BOLD (SEE TEXT)

Panel of Psychological Inquiry Advocate Claims

The Advocate will be making four claims:

Claim 1. Without reservation, it is absolutely clear that the patient, "Anna", presented with a serious psychopathology.

> Physical evidence will consist of client's Counseling Center Student Request For Services Form and the Contact Record, to establish symptomology and its longevity. The college nurse's progress note will be used to establish client's anxiety about increasingly severe cuts.

Witnesses to be interviewed will include Stacey Podetz and Andrea Kelly, Ms. Podetz's clinical supervisor.

While I acknowledge Anna's self-mutilating behavior as an important symptom of psychopathology, I would also like to investigate the history of her affect, self-understanding, and social and family interactions as revelatory of core distress. This line of questioning may be especially important because it is connected to the question of the measure of therapeutic efficacy (Raised explicitly in Claim 3). Is it reasonable to use symptom relief as the primary metric for therapeutic efficacy and, if so, what symptoms or set of symptoms do we emphasize in the evaluation of this case?

Claim 2. It is clear that Stacey, the therapist, provided humanistic, psychodynamically informed therapy to "Anna".

> Witnesses Andy Kelly and Stacey Podetz will be interviewed. Stacy's testimony will be used to establish the origins of her theoretical background, her training/coursework in this area, examples in the case study of how she provided genuineness, empathy, respect etc. as well as psychodynamic interpretations connecting anxiety to hidden feelings, the past to the present. I will also take this opportunity to question her about her familiarity with DBT and ask her why she conceptualized the treatment in the way she did. Andrea Kelly's professional background will be examined, and I will introduce her resume as evidence. I will be seeking confirmation from her that in her professional opinion Stacey's work with "Anna" reflects the two orientations postulated.

By way of clarifying her understanding, I would like to pursue the question of what Stacy thinks the relationship is between the humanistic and psychodynamic approach. Are the two approaches always complementary? Were there any moments in the therapy when

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these approaches competed with one another or were in tension? If so, was there a principled choice that was made to determine what approach was taken?

Does Stacy see any relationship between the approach she has taken with Anna and a DBT approach? Are there specific reasons why she avoided any introduction of mindfulness techniques as a possible strategy to combat cutting urges? Did Stacy ever conceptualize the patient as someone with a "borderline personality disorder" and, if not, was this because she felt such a diagnosis did not adequately capture Anna's presentation?

Claim 3. This case demonstrates the capacity of a first year intern to be demonstrably useful in providing therapy to clients in a counseling center, as we maintain that it is highly probable that the treatment resulted in increased health and growth.

Witnesses will include Stacey Podetz and Andrea Kelly. The testimony of Stacey will be used to establish that she had good reason to believe her client when she made claims that she was or was not cutting. I will refer back to the first sessions and Stacey's sense of Anna's truth telling when she gave facts about the number of her family members and the divorce history of her parents and that it corresponded to her later affects when discussing cutting episodes.

I will establish that Stacey observed physical clothing changes that supported knowing when the client cut or had refrained, and that there is evidence that when her client prevaricated, Stacey was aware of it. Evidence that there was improvement will consist of a) the reduction, then cessation of cutting as reported by the client. b) a change in the client's affective presentation as observed by the therapist. c) instances of insight in the client not previously expressed, relating to identification of specific emotions towards specific individuals and its relation to the cutting behavior. (as observed by the therapist) d) the emergence of creative writing as an activity, which shows, in a free associative manner, that "Anna" is beginning to use words to express feelings about relational material.

I will introduce the March 26th session transcription which includes "Anna's" writing and ask Stacey to read a portion. e) I will ask Andrea to relate an incident conveyed to her by a professor of Anna's which details a challenging interpersonal incident and "Anna's adaptive response to it, including Andrea's own perception having met one of the participants. I will be using Andrea's testimony to establish Stacey as a reliable reporter as well as to substantiate the claim of improvement.

As suggested in my response to 1, it seems important to examine carefully the metrics for therapeutic success. With regard to the specific metrics suggested:

a). Did the therapist have visual access to the scars and recent cuts of the patient? Could the patient have been cutting in other areas of the body not visible to the therapist or anyone else? If Anna's cutting has indeed been reduced, is it possible that this symptom has been replaced by another, subtler signal of distress?

b). Was the suggested change in affect noticeable by others in the patient's sphere of relationships? If this change in affect occurred or was noticed only in the therapist's office what impact would this have on our evaluation of the meaning of the change?

c). Similarly, was this proposed insight of Anna expressed in other ways outside the therapy setting? Did her behavior or attitude toward her parents change? Was there a shift in expectations that others noticed? Did Anna speak about herself in different ways to her friends?

d). Does Anna's writing activity carry the import suggested? If it is not accompanied by a critical reflection on Anna's part, might it even be damaging or at least therapeutically unproductive? (I think this is related to the question of whether something like catharsis can occur simply through emotional expression or whether a therapeutic catharsis requires a cognitive component involving some rational evaluation of affect.)

e). Can evidence be presented suggesting that Anna would have acted in a significantly different manner prior to treatment? What improvements does the interaction illustrate? Is there some way in which Anna's public persona might have changed but her private persona remained relatively unchanged?

If it is indeed the case that in this instance a first year intern "was demonstrably useful" for a client, is it possible that this utility consisted primarily of elements peripheral to the therapy (e.g., the therapist's gender and age) or of elements characteristic of the activity of therapy but not central to the therapeutic conceptualization (e.g., the therapist's enthusiasm or compassion)?

Reportedly, Anna had not cut herself for 10 months prior to the stress of leaving home and entering college as a freshman. Is it possible that she would have improved on her own, after stabilizing in the college environment, without any therapy?

Claim 4. Stacey's premise, that "Anna's" cutting served a self-regulatory function as it offered relief from the tension of both numbness and excessive anxiety, was valid and critical to the client's eventual growth.

Witnesses consist of Stacy Podetz and Andrea Kelly. Stacy will testify to how and when she arrived at this interpretation. I will ask her to give examples of when the client confirmed this understanding. I will ask her to speak to the articles by Favazza and Conners which informed and confirmed this interpretation for her and introduce them into evidence. I will question Andrea, based on her professional experience, about the correctness and adequacy of this formulation.

I would like to question whether this interpretation best explains the phenomenon of self-mutilation in Anna's case and whether a client "confirmation" of this interpretation is

the best measure of its validity. An alternative interpretation is that Anna's cutting represents her self-disgust, an attitude toward her identity that can be tied to early attachment issues, her parentification, and her consistent impression that her parents did not respect, cultivate, or appreciate her emotional life. Is it possible that both Anna's numbness and her excessive anxiety had their origin in this self-disgust and that the capacity of her cutting to provide relief is tied to her need to express this attitude in an infantile fashion, by using the physical material of her body rather than the representational material of speech.

Of course complex events are often complex by virtue of their many layers of causation so one interpretation does not necessarily exclude the other but it might be relevant to examine whether these different interpretations would lead to different treatment strategies.

There is also the theory that endogenous opioids, presumably released as a result of cutting, are somehow involved in the reinforcement of this behavior. If this is true, one might approach such a client as Anna as having a substance abuse problem (i.e., a kind of opiate addiction). Would the treatment have changed substantially if Anna had been conceptualized as someone having a co-occurring disorder?

I do not plan to call any witnesses in the afternoon session other than Stacy. My preference would be to devote the time we have after lunch to a consideration of the role that countertransference played in the therapy.

APPENDIX D: JUDGES' FEEDBACK FORM

Case Study Panel of Psychological Inquiry
Case of "Anna"
May 13, 2008

Advocate's Claims Evidence/Warrant Rebuttal/Backing

1.

I accept/reject (circle one) Advocate Claim #1 based upon the preponderance of evidence for the following reason(s):

(This format is repeated for each claim)

Case Study Panel of Psychological Inquiry
Case of "Anna"
May 13, 2008

Critic's Counter-claims Evidence/Warrant Rebuttal/Backing

1.

I accept/reject (circle one) Critic's Counter-claim #1 based upon the preponderance of evidence for the following reason(s):

(This format is repeated for each counter- claim)
