Feedback Informed Treatment

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Learning Objectives

This chapter provides an overview of Feedback Informed Treatment (FIT), including its historical evolution, guiding principles, central tenets, and practical application. As a result of reading this chapter, readers will:

1) Learn about the research foundations of Feedback-Informed Treatment (FIT)
2) Learn about measuring therapeutic outcomes and the alliance
3) Consider diversity in FIT implementation
4) Lean about *deliberate practice* – individualized activities aimed at improving performance.

Keywords: psychotherapy; psychotherapy outcome; therapeutic alliance; feedback; deliberate practice; routine outcome measurement; psychotherapy integration

Introduction

A friend and colleague of the authors, Birgit Valla, recounts an unforgettable story:

> *I worked with a young boy accompanied by his mother. I read up on different therapeutic approaches for children and tried to follow the most appropriate method to the best of my abilities. With a supervisor and three fellow students monitoring everything I did from behind a one-way mirror, I was certain that the therapy was carried out in the best possible way. After every session, we discussed the therapy in a tutorial. I received good feedback on my relationship with the boy and everything of interest that emerged in our*

> *sessions. His statements were analysed in light of the issue in question along with my interventions as a therapist. The boy's mother sometimes attended the sessions, while on other occasions she sat in the waiting room. The therapy was carried out as prescribed, the boy and his mother seemed satisfied, and eventually we approached the final session. As a conclusion to the therapy, I had a session with the mother to sum up and ask her about how she had experienced the contact…*
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> *The mother arrived for our appointment and … seemed a bit uncomfortable and I asked her how she thought the therapy had been. She … was quite disappointed with all of it and did not think it had helped very much with the boy's problems. She'd had completely different expectations for the help they would receive and described what she had envisioned. It turned out that she had very clear ideas. I listened to her feedback, resisted the need to defend myself and hoped that I demonstrated understanding for her experience. We then ended the session and said our goodbyes. (Valla & Prescott, 2019, p. 2)*

It seemed apparent that Birgit was providing good treatment with ample guidance from her colleagues, but clearly something was missing. Far from a unique situation, is the case represents a kind of outcome that could happen to anyone. Ironically, truly "bad" clinical experiences are easily observed ~~and scrutinized~~, while mediocrity can continue unnoticed for long periods of time. This can happen even to clinicians, therapists, and other professional who aspire to do their very best.

Coming out of this experience, Birgit started incorporating client feedback at the beginning and end of every session. Like many others, she has often been amazed by what does – and doesn't – make a difference in therapy. Feedback Informed Treatment (FIT) grew out of the discovery which, as Birgit experienced, when so many treatment approaches focus on models and techniques have has positive results across wide swaths of people, it's easy to forget how the smallest events can alter the course of treatment for better or worse at the individual level (Giorgi, 2011).

What Is Feedback Informed Treatment?

Since the late 1990s, FIT practice has evolved out of the recognition that not all therapies work for all clients, and that therapists do not always identify clients at risk of therapy failure. FIT is a transtheoretical approach that uses ongoing administration of outcome and alliance measures to collect real-time client feedback about their experience in therapy. "Transtheoretical" means that FIT can be applied across disciplines, no matter what treatment approach the therapist is using. The goals of FIT target two fundamental aspects of mental health treatment: (1) improving individual client outcomes by identifying clients at risk of treatment failure so adjustments to treatment can be made to get treatment on track for success and (2) increasing the effectiveness of individual therapists over time.

FIT is an evidence-based practice that merges "the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (APA

Presidential Task Force on Evidence-Based Practice, 2006, p. 273). It offers a practical system for the "monitoring of patient progress (and of changes in the patient's circumstances – e.g., job loss, major illness) that may suggest the need to adjust the treatment… (e.g., problems in the therapeutic relationship or in the implementation of the goals of the treatment)" (APA Presidential Task Force on Evidence-Based Practice, 2006, pp. 276-277). FIT can improve the likelihood of positive therapy effects and encourage therapists to focus on growth and development as they attempt to improve their effectiveness throughout their careers.

Guiding Principles of FIT

FIT practitioners believe treatment should offer ~~some~~ benefits for ~~participating~~ clients. Continuing to provide service when there is no measurable improvement or where there is evidence of deterioration may be costly and unethical. For these reasons, clinicians should monitor the effectiveness of treatment with each client and make adjustments when clients report a lack of progress (e.g. change approach, intensity, or provider).

Since client engagement and participation are vital to positive treatment outcomes (Prescott, Maeschalck, & Miller, 2017), FIT therapists use empirically validated alliance and outcomes measures to monitor two factors that have been demonstrated to improve engagement in real time:

(1) the client's subjective view of the therapeutic alliance;

(2) the client's subjective experience of change.

The therapeutic alliance relies on client preferences and agreement between client and therapist about the goals of treatment, the nature of the relationship, and the means and methods used to reach those goals (Bordin, 1979).

Research into the power of the therapeutic alliance has been thoroughly established in over 1100 research findings (Horvath et al., 2011).

The therapeutic alliance is a strong predictor of the eventual outcome of therapy. A strong alliance generally leads to a positive outcome, while a weak alliance often ends with drop-outs and null outcomes (Prescott, Maeschalck, & Miller, 2017).

The client's perception and feedback about the therapeutic alliance offers a better forecast of outcomes than assessments made by therapists (Horvath et al., 2011). Research consistently shows that clients and therapists experience therapeutic relationships differently: clients may not necessarily perceive the therapist's actions in the way the therapist may have intended. The research suggests that clients and therapists often attribute therapeutic change to different experiences and influences (Horvath, Del Re, Flückiger, & Symonds, 2011). In order to ensure their effectiveness, FIT practitioners administer empirically validated alliance measures specifically designed to elicit the client's subjective view of the alliance on an ongoing basis. Formally monitoring the client's perception of the alliance through feedback measures at each session helps

clinicians identify when treatment is not going in the intended direction and clients may be at risk of dropping out, even when they appear to be engaged. ~~Early identification of flaws in the therapeutic alliance provides clinicians the opportunity to clarify client preferences and make adjustments to meet the client's needs, thereby strengthening the alliance and client engagement.~~

Monitoring the clients experience of change, especially early change, is the second factor routinely monitored by FIT practitioners. Early measurable change is a strong predictor of client engagement and, in turn, of therapeutic outcome. Several ~~large~~ highlight the importance of monitoring early change, suggesting that clients who experience little or no change in the first handful of sessions are likely to drop out or continue in treatment in the absence of change, while losing hope that therapy can help (Owen, Adelson, Budge, et al., 2015; Stulz, Lutz, Lucock, & Barkham, 2007). Lambert (2013) found that as many as 30% of people remain in treatment with no measurable benefit. In the same study, Lambert (2013) found a 90% chance of treatment failure if there is no change between the second and eighth visits. Thus, FIT practitioners strive to maintain engagement and ensure that change is ongoing.

In sum, FIT is an evidence-based practice that involves regularly collecting client feedback to measure the alliance and outcome, and discussing progress in these areas with the client. This information can help guide practice decisions. Maintaining engagement and ensuring that change continues is essential to successful therapy

outcomes. Routinely monitoring client feedback about their experience and progress in therapy:

1. Helps to inform and refine service delivery to best meet each clients needs and improve the chances of positive therapy effects;
2. Serves as an early-warning system for when treatment is going off-track as well as providing ideas about the best ways forward;
3. Assists professionals in improving their skills at helping people; and
4. Helps agencies to reduce the variability between clinicians with respect to their effectiveness.

Core Competencies of Feedback Informed Treatment

Four core areas of competence of Feedback Informed Treatment guide FIT practitioners (Miller, Maeschalck, Axsen, & Seidel, 2011; Prescott, 2017). ~~These are:~~

Competency 1: Research foundations~~, includes familiarity with:~~

- the research on the therapeutic alliance,
- research on behavioral healthcare outcomes,
- the general research on expert performance and its application to clinical practice, and
- the properties of valid, reliable, and feasible alliance and outcome measures.

Competency 2: Implementation~~, includes:~~

- integration of consumer-reported outcome and alliance data into clinical work,
- collaboration and transparency in interactions with consumers about collecting feedback,
- using the resulting information to inform and tailor service delivery, and
- ensuring that the course and outcome of behavioral healthcare services are informed by consumer preferences.

Competency 3: Measurement and reporting~~, includes:~~

- measuring the therapeutic alliance and the outcome of clinical services on an ongoing basis with consumers, and
- providing details in reporting outcomes sufficient to assess the accuracy and generalizability of the results.

Competency 4: Continuous professional improvement~~, includes clinicians:~~

- determining their baseline level of performance,
- comparing their level of performance to the best available norms, standards, or benchmarks,
- developing and executing a plan for improving their performance, and
- seeking performance excellence by deliberate practice.

When and where does FIT apply?

For any treatment setting, modality, or client type, FIT offers valuable guidance that can be used in almost every situation. For example, FIT can be used in residential programs, intensive day treatment, outpatient and outreach settings with individuals, families, couples, groups, adults, adolescents, children, and even young children. FIT works with voluntary clients as well as clients who are mandated. FIT is also used successfully in many different countries and with many different cultural groups around the world.

Background Information: Why all therapists should use FIT in their practice

Psychotherapy is effective for reducing distress and improving well-being. ~~This has been solidly established through decades of research.~~ Consistently, clients who engage in treatment are better off than people in control or comparison conditions, or those who receive no treatment: between 0.8 and 1.2 standard deviations above the mean

of no treatment or control conditions (Lambert & Ogles, 2004; Smith, Glass, & Miller, 1980; Wampold, 2001). The effectiveness of psychotherapy is often equal to or greater than many medical treatments (i.e. chemotherapy for breast cancer; coronary bypass surgery for heart problems). Psychotherapy is also far more cost effective than many medical treatments and with fewer negative side effects (Schuckard, Miller, & Hubble, 2017; Wampold, 2007).

Even with the obvious benefits of psychotherapy, clients who no-show, dropout, and ~~clients who~~ do not progress despite the therapist's best efforts present an ongoing concern. The dropout rate for therapy remains stubbornly high -about 25% for adults and 35% for adolescents and children (Swift & Greenberg, 2012; Weisz, Sandler, Durlak, & Anton, 2005) and many clients who seek therapy do not benefit, or get worse. This can only create an enormous financial burden for the health care systems.

To make matters worse, clinicians often fail to identify clients at risk for premature termination or negative outcomes. Hannan and colleagues found that clinicians anticipated negative client outcomes in less than 5% of cases (Hannan et al., 2005). Clinicians' and clients' views of how therapy is progressing can stray widely, begging the question: What can therapists do to more accurately identify when clients are at risk of dropping out or when treatment is failing?

Routine outcome measurement (ROM) systems such as FIT can help. Over the last two decades, substantial research suggests that using client feedback about the

alliance and progress in treatment to inform and guide practice decisions provides significant improvements in the effectiveness of therapy. Lambert, Whipple, and Kleinstäuber's 2018 meta-analysis of 15 randomized clinical trials (RCTs) found that therapists who received ongoing feedback and clinical support tools showed outcomes with deterioration rates in at-risk patients improving from an average of 30% to 12% and increased by half the likelihood of at-risk clients experiencing positive outcomes.

Studying an additional nine RCT's including 2,272 clients Lambert et al. (2018) found that feedback produced an average effect size of .40 on client outcomes. When Miller, Duncan, Brown, Sorrell, and Chalk (2006) provided therapists with ongoing, real-time feedback regarding the client's experience of the therapeutic alliance and progress in therapy, they found higher retention rates and a doubling of the effect size (baseline ES = .37 v. final phase ES = .79). Ongoing client feedback regarding the working relationship and progress in treatment not only increased success rates but also improved the cost-effectiveness of services.

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Frequency and immediacy of feedback also play a key role in improving the outcome of therapy. Slade, Lambert, Harmon, Smart, and Bailey (2008) found that immediate feedback had a larger impact on outcomes than feedback that was delayed by two weeks.

Some studies suggest that the impact of FIT may not have a positive impact on outcome or the effect may not be as pronounced as was first thought (Davidsen, Poulsen, Lindschou, et al., 2017; Mikeal, Gillaspy, Scoles, & Murphy, 2016; Østergård, Randa, & Hougard, 2020). However, these recent studies show that the impact of FIT is tied to differences in therapists and that it can take several years to implement successfully (often two to four years). Therapists who implement FIT require ongoing training and supervisory support to achieve the full benefit that FIT offers in terms of outcome. For example, Heidi Brattland and her colleagues (2018) studied the effects of FIT in an outpatient mental health setting. They found:

- Differences between therapists accounted for 9%–10% of the variability in outcomes.
- ROM was associated with better treatment outcomes independent of clients' initial distress levels.
- Over the four-year duration of the study, ROM had increasing superiority over treatment as usual.
- No effect in the first two years.

What are the implications of these findings?

- Therapist effects are essential to outcomes.
- It takes time to implement an effective ROM program.
- Training and supervision of therapists must be sustained over time.

What does FIT look like in practice?

FIT does not designate specific outcome and alliance measures that practitioners must use to gather client feedback (although it requires that they be valid and reliable

measures). Although many options are available to measure alliance and outcomes, longer formats take more time to administer, making them impractical for regular use. ~~Indeed,~~ The use of feedback measures decreases when they require more than five minutes to administer (Brown, Dreis, & Nace, 1999).

The Outcome Rating Scale (ORS; Miller & Duncan, 2000) and the Session Rating Scale (SRS; Johnson, Miller, & Duncan, 2000) are commonly used by therapists implementing FIT. These scales are brief measures that have proven feasible for regular use and demonstrated reliable and valid results. Designed to minimize complexity, the ORS and SRS are visual analog scales with no numbers or markers on the scale. Visual analog scales remove the preconceived values that people attach to numbers. Consequently, they also tend to have good face validity. So, rather that asking the client to use a numerical value to rate their experience or progress, the client is asked to mark a line at a point nearest to whichever end (positive or negative) is closest to their experience.

The ORS and SRS provide a snapshot of client well-being and functioning along with their experience of the alliance within each session that can be monitored over time. The ORS measures change in three areas of client functioning: individual (or symptomatic) functioning, interpersonal relationships, and social role performance (including work and quality of life). The SRS measures the major elements of a good therapeutic alliance including four interrelated domains of the therapeutic alliance:

- the quality of the relationship between the client and therapist,
- the degree of agreement on the goals of treatment,
- agreement on the methods used,
- and agreement on overall approach to therapy.

Age-specific versions of the ORS and SRS are available for use with adults, adolescents, and children. This makes FIT applicable to diverse client populations. A group session rating scale (GSRS) measures the client's alliance with other group members as well as the group facilitator. Oral versions of ORS and SRS are available for use over the phone and can be useful with clients who have problems with literacy, eyesight, or a strong preference against paper or electronic versions of the measures. As of 2020, the measures have been translated into 19 different languages and are in use around the world.

The adult versions of the ORS and SRS are designed for clients who are able to read at a grade six level or higher, and are normed for people 13 years and older. The Child Outcome Rating Scale (CORS) and Child Session Rating Scale (CSRS) can be used by children aged 6-12 with a grade two (approximately) or higher reading level. The simplified language in the measures means that they are also applicable to adolescents or with adults who have challenges in the areas of literacy or language. Adaptations of the measures are also available for use with very young children lacking literacy skills (typically under six years old). These are called the Young Child Outcome Rating Scale (YCORS) and the Young Child Session Rating Scale (YCSRS). They use three pictures representing a happy or smiley face, a neutral face, and a frowning or unhappy face,

which young clients choose to represent their experience. A fourth blank feeling face provides an option to draw their feeling if the other three faces do not adequately capture the child's experience. Because these measures do not have any numeric assignment or measurable scale, they do not provide a purely arithmetic measure of change. However, they engage young children in providing feedback, and that matters.

FIT practitioners gather feedback in real time. To be most effective, outcome measures need to be administered as early as possible at the initial session and each session thereafter to capture a baseline of the client's distress and measure change over time. The alliance measures should be administered at the end of each session. The initial alliance score provides a baseline from which the therapist works to improve engagement over time.

Tracking and graphing outcome and alliance scores allows the therapist and client to observe changes over time, providing an excellent basis for clinical discussion. Initially, this was done by plotting the scores on a paper graph. Since then, more technical solutions have been developed to facilitate tracking scores. These computerized applications allow clients to complete the measures on a tablet or other device. The software then scores and tracks client data, providing alerts when data indicates potential problems with the alliance or lack of progress. These systems are highly efficient, user friendly, and quick.

Typically, the session schedule and length of treatment depends on client progress. Psychotherapy is most effective when the client wants to continue with their therapy and meaningful change is evident. When positive change occurs rapidly, increasing the frequency and intensity of treatment can maximize gains. When positive change slows or diminishes, it may indicate a need to focus on consolidating change and transitioning out of therapy. The frequency of sessions may taper off with treatment lowering in intensity.

Therapists' views on collecting and using patient feedback can vary dramatically. Their attitudes can actually influence change. Therapists who value feedback achieve better outcomes (Miller, 2014). FIT measures change by outcome data and client feedback, not simply by the therapist's impression of improvement. Therapists can use any theoretical approach to achieve patient change, but if the data indicate that the approach is not working, the therapist is best positioned to make adjustments. Lack of change within the first few sessions (typically by the third session) merits evaluating the frequency, intensity, or method of treatment. Therapists and client working together can examine the alliance in detail and adjust their approach as needed. If the lack of significant change continues despite these adjustments, it may be time for bigger changes to the treatment approach or a referral to a different therapist.

Creating a Culture of Feedback

Even though FIT is being used in various settings using many kinds of treatment approaches and with diverse client populations, therapists sometimes doubt the relevance of FIT or the validity of client feedback. A common question is whether clients who have been diagnosed with severe and persistent mental illness or have cognitive impairment are capable of providing valid feedback. Validation studies do not support such conjecture (Prescott et al., 2017). In fact, research consistently indicates that it is therapist and not client variables that impact outcomes the most (Schuckard et al., 2017). In all cases, it is useful to obtain feedback regarding the client's experience. Besides providing a measure of change, FIT uses feedback to engage clients in dialog. Given the subjective nature of the measures, each client's scores hold unique meaning for them. The job of the therapist is to interpret the results and work with clients to find a way forward that works for each client. Outcome and alliance measures provide an overview a client's situation. Clarification of the meaning of the scores comes through dialogue with the client.

Using feedback to engage clients in discussions about their experience and progress in therapy contributes to improved outcomes (Hawkins, Lambert, Vermeersch, Slade, & Tuttle, 2004; Schuckard, et al., 2017). Therapists should create a transparent and open environment that encourages clients to provide detailed and honest feedback. Creating a "culture of feedback" from the onset of therapy is key.

For example:

Therapist (T): It's important that we make sure our time together has the best chance for success. It will help if you'd be willing to complete two quick measures each time we meet – one at the start and one at the end of our sessions. Most of the time, when treatment works, we should start seeing progress sooner rather than later. These tools help us see if the time we spend together is helping you. If things aren't getting better, then we'll talk about what changes we might make to get us going in the right direction. If you fill in the first measure at the beginning of each session, it will tell us if things are changing for you. The second one is for the end of each session. It will ask you how you think the session went and whether you believe I understand what you need. It's kind of like when your doctor gives you medicine for a fever and then checks your temperature to make sure the medicine is working. Would you be willing to do this with me?

Creating an environment where clients are at ease providing feedback is easier said than done. The desire to be viewed positively can leave clients fearful of the consequences of honest feedback and reluctant to give negative responses. Blanchard and Farber (2015) found that over 90% of adult psychotherapy patients report having lied to their therapists. The study reported one of the most common lies was that the client likes or benefits from their therapist's interventions more than they actually do. Unfortunately, fixing hidden problems is nearly impossible. Soliciting negative feedback is essential because it can guide efforts to meet client needs and align more closely with their

preferences. Ironically, the most effective practitioners receive more negative feedback than their more average counterparts (Miller, Duncan, & Hubble, 2007; Owen, Miller, Seidel, & Chow, 2016), clearly demonstrating how an open and forthright environment where clients feel confident giving honest feedback will benefit the therapy process.

FIT Methods and Techniques

Because clients are diverse, clearly no single treatment approach will work for everyone. When practicing FIT, outcome outweighs technique. The treatment approaches should depend on the probable effect they will have on client outcomes. When feedback scores indicate problems with the alliance and/or a lack of progress, therapists can tailor or change their treatment plan (for example, the frequency, type, or intensity of treatment method).

One of the biggest mistakes in implementing FIT happens when therapists don't value feedback measures adequately, or use them carelessly. This can include administering the measures without ~~actually~~ discussing the scores with clients or not using the feedback to guide therapy. Feedback summaries, including charts that display outcomes, should be shared with clients and form the basis of discussion around the alliance and therapeutic progress. Based on clients' input, therapists can adjust their approach to align with client preferences and ultimately better meet their needs. Once clients understand the purpose of feedback and its value in improving treatment effectiveness, therapists can administer the ORS as early as possible in each session

thereafter unless there is a specific reason not to, such as frequency of sessions. In order to prevent measurement fatigue, therapists should not expect clients to fill out the measure any more often than once per week. Administering the ORS as early as possible (ideally, in the first session) is useful because it provides a baseline of client functioning.

The SRS is best used close to the end of each session, leaving time to discuss the client's scores with them. This timing is essential so that the therapist and client can discuss elements of feedback that require attention. Since the alliance between therapist and client carries such influence and is predictive of treatment outcome, therapists should address any indication of an alliance problem or rupture as soon as possible. Acting quickly can prevent the premature termination or worsening of treatment.

Some outcomes patterns can raise red flags. When a client's initial score points to functioning in the normal rage of distress, therapists should proceed with caution. For example, in the case of a voluntary client seeking help with a specific concern, long-term, depth-oriented techniques may not be necessary, while problem-solving techniques focused on the immediate presenting concern may be more appropriate. Alternatively, when dealing with **involuntary or mandated clients**, asking them to complete the ORS based on how the party that sent them to treatment would score the measure can yield interesting results. This provides an opportunity to compare the clients' self-perception to that of the referral source (which may include judges or probation officers). It also fosters discussion about the kind of change the referral source would want to see in order to feel

satisfied that client has addressed the issues that led to treatment. In other cases, such as with adolescents, outcome scores that increase and decrease dramatically can indicate that the young person experience rapidly changing circumstances where they do not feel in control.

While having clients stay in therapy for longer periods of time can consolidate treatment gains (and prevent reversion to past behavior), diminishing returns can happen when the central goals are met, feedback scores plateau, and clients continue treatment without further demonstrable change. When clients have made positive changes and their scores level off, it is time for therapists and clients to explore reducing the frequency of sessions and begin planning to end services. If maintenance sessions retain the same frequency and intensity of earlier therapy, client scores can begin to fluctuate noticeably. This pattern can signal the ups and downs of the client's daily life rather than meaningful changes over time.

Sometimes, ORS scores will plummet after positive change has taken place – a phenomenon known as "ditching." Often, this is due to an extra-therapeutic variable – some event that takes place outside of therapy. If this happens, clinicians can explore each domain of the ORS in detail to establish whether external variables could be affecting the scores. Monitoring change over the ensuing weeks creates opportunity for quick recovery of these treatment gains.

Considering Diversity

People have been marginalized on the basis of their race, ethnicity, nationality, gender, age, sexual orientation, gender identity, religion, physical ability, socioeconomic status, and body size. Failing to consider the impact of marginalization can lead to power imbalances that contribute to clients' distrust and discourage them from providing honest feedback regarding their psychotherapy. Yet, cultural competence is rarely as straightforward as it might seem. In a recent review of the literature, Hayes, Owen, and Nissen-Lie (2017) debunk three prevailing myths about cultural competence, including that it involves a high level of education about different cultures, that therapists need to develop a therapy-specific language to work with cultural minority clients, and that therapists do not need to concern themselves with matters of culture.

Numerous studies have demonstrated significant differences both between therapists and within individual therapist's practice outcomes influenced by culture, race, and ethnicity (Flückiger, Horvath, Symonds, et al., 2013; Fuertes, Mislowack, Bennett, et al., 2007; Hayes, McAleavey, Castonguay, & Locke, 2016; Hayes, Owen, & Bieschke, 2015; Imel et al., 2011; Larrison, Schoppelrey, Hack-Ritzo, & Korr, 2011; Worthington, Mobley, Franks, & Tan, 2000). Such results commonly show that variations in effectiveness are unrelated to therapist gender, years of experience, self-perceived cultural competence, professional degree, theoretical orientation, or their own race or

ethnicity. As Hayes et al. (2017) emphasized in a review of the evidence, “No therapist is immune from having [cultural] disparities in their caseload” (p. 162).

Central to FIT is gathering feedback that can help clinicians shape services to fit the individual client. The very nature of FIT offers an opportunity to build specific guidelines for creating a culture of feedback that maximizes opportunities for attending to diverse client backgrounds, experiences, and ways for making sense of the world (Bertolino & Miller, 2013). In particular, the SRS is designed to alert therapists to:

- differences in understanding,
- goal consensus,
- and preferences related to identity, so they may be discussed and addressed directly.

This means that FIT, used properly, can be an excellent means for ensuring that cultural differences are respected in therapeutic practice, as well as for providing avenues for deliberate practice on the part of therapists.

Although FIT has proven versatile across many countries and cultures, providing direct feedback to health professionals is not always the norm. In some cultures, it may conflict with deeply held cultural as well as personal values. Even the outcome being measured may present challenges. One especially piquant example is the domain of personal well-being, which is included on many outcome measures. This domain may take on different meanings and be of less personal relevance to the client in cultures where people experience well-being within the context of relationships (Bertolino & Miller, 2013; Koo, Dion, & Rice, 2016). Creating space for the client’s perspective in this

example could involve choosing a method and measure for seeking feedback in which well-being refers to the experience of the people closest to the client.

In another example, from the United Stated, older adults were frequently taught in their youth not to critique or evaluate a professional's activities, especially when they are in an expert position. Still other clients can be unwilling to provide feedback in every session. For some US adolescents, rejecting the measures can be an act of asserting independence, which can be developmentally appropriate. Cultural adaptations in the use of feedback can take place within the basic FIT principles of therapist flexibility amid strongly held client preferences. To this end, Miller and colleagues have produced a comprehensive and detailed series of FIT manuals. Manual 5 guides therapists on how to apply FIT across diverse settings, cultures, and clients (Bertolino & Miller, 2013).

In still another example of how culture can play a role in routine outcome monitoring, Rodriguez, Terrones, Brookman-Frazee et al., (2019) found that "stronger cultural heritage identity was related to potential harm with routine progress monitoring" (p. 1). The authors found that this concern about potential harm had little to do with the therapist's cultural background. They further suggest that their findings may be due to the potential for cultural misapplication of otherwise evidence-based assessment and treatment practices. These findings point to the importance of a nuanced understanding of FIT and how it can be used in the most helpful way possible.

So, how does FIT practice address cultural diversity more directly? After the translation of the ORS and SRS measures available in multiple languages, several FIT implementation efforts are now underway in various settings involving diverse populations. Unlike other measures to date, comparisons of clients from different countries and cultures have not shown differences in either the psychometric properties of the measures or the predictive trajectories (Koo et al., 2016; Schuckard et al. 2017; Miller, Bargmann, & Wampold, in preparation).

Next, the current algorithms are based on over a million cases. These have been tested and found not to vary across major ethnic and minority groups. These algorithms are in use with FIT software packages such as www.myoutcomes.com. Finally, in a recent publication, Miller, Hubble, and Chow (2020) describe methods for using aggregate data to check for outcome differences when working with various kinds of people, including along cultural lines, and offer suggestions for how to improve their performance using deliberate practice.

Case Example

As an example of FIT, consider the following experience from the first author's practice. It involves the integration of ongoing feedback into clinical services as well as using measures of outcome and the alliance to track outcomes. Finally, it also involves what the first author did to improve his clinical practice as a result:

Derek was 17 years old when his adoptive parents referred him for

treatment. Adopted at the age of ten, Derek had previously received treatment for concerns related to trauma and neglect in his family of origin. Having received diagnoses from previous providers (such as Conduct Disorder and Attention Deficit Hyperactivity Disorder), his problems revolved around attempting to view his mother naked and in various stages of undress as she showered and got dressed.

Treatment took place in an outpatient setting. Derek's mother had sought out the author due to concerns that when he wasn't attempting to spy on her, he sometimes hugged her to an inappropriate extent (e.g. ~~very~~ frequently and often while he had an erection). Further, his mother was concerned that he seemed to have difficulty negotiating conversations with young women in his school and was fearful that he would act provocatively and inappropriately with them. Our first session was straightforward, and Derek took the Outcome Rating Scale (ORS) ~~very~~ seriously (Derek would do this throughout our work). His initial ORS scorewas 22 out of a possible 40, well below the cutoff for adolescents of 28. As his therapist, I used motivational enhancement and cognitive-behavioral therapy to explore the difference between Derek's current and desired future states.

At the end of the first session, Derek thought carefully about the SRSand returned a score of 37, nearly perfect except for a score of 7 out of 10 on the item related to the therapist's approach. Suspecting that this is part of a typical pattern

of responding on the SRS in which clients provide very high scores and the challenge for therapists is to elicit negative feedback, I asked for his thoughts on my approach. Derek stated bluntly, "You need to ask me a lot more questions. You need to be really hard on me or else I'll just lie to you, and I don't want to do that."

This feedback came as a surprise as I had specifically been using reflective statements in place of questions to avoid seeming like a criminal interrogator. More to the point, I have worked to develop this approach over many years, and here was Derek telling me to do the oppositeOf course, self-identifying as a provider of treatment X or Y may come at the cost of actual helpfulness with clients like Derek who don't like those particular approaches. Had I not explicitly asked for feedback, he may well have come to view me as naïve or unable to connect with him.

~~*Of course, while*~~ *Derek may have been the expert on what would work for him, but I still possessed considerable knowledge about adolescents with problems related to sexual behavior. It was clear that if all I did was become brusque, I would not only lose our alliance but provide Derek with further opportunities for not engaging in treatment. I've often found that professionals in my field are who others turn to when directly confrontational approaches haven't worked.*

Adapting my style with Derek required consistent checking in on the alliance to ensure that it was working. Indeed, Derek responded well to a combination of very direct feedback on my part mixed with a steady stream of validation. As soon as Derek began to offer excuses or externalize blame of his actions, I would say something like: "Look, I'm your biggest admirer, but nothing seems to be changing. With all due respect, if this behavior continues, what is going to happen?" This delivery turned out to be critically important. By being direct but not harsh, Derek still ended up, in essence, confronting himself.

Derek's SRS scores went up and generally hovered between 38 and 39 on this 40-point measure. He never provided a full 40, saying that absolutely no one is perfect, but offering no specific feedback beyond this. He did, however, come to take a diligent approach towards improving his relationships with others, most specifically his adoptive mother.

Ultimately, Derek's ORS scores rose to 32 and stayed there, despite small conflicts with his mother over keeping his room clean and attending to household obligations. His inappropriate behaviors with sexual overtones had stopped altogether. Statistically, his ORS scores indicated a reliable level of change.

In the end, Derek was able to make significant changes to his life on his own terms and not because of his therapist's preferred approaches. Being Derek's therapist meant stretching beyond my familiar approach at the time and

reaching for what would work for him in the long and short terms. What I learned from Derek (and what other colleagues have observed informally) is that the concept of confrontation is best considered in conjunction with a goal that the client can accomplish; in the long run, it is not an effective technique on its own. I developed new skills, such as being highly directive while remaining affirming, and I have been able to use these refinements to my skill-set in other venues with success.

Outcome Research

In 2012, the U.S. Substance Abuse and Mental Health Services Administration formally recognized FIT as an evidence-based practice and listed it on their National Registry of Evidence-Based Programs and Practices (https:/www.samhsa.gov/nrepp). Since then, the number of RCTs on FIT (using the ORS/SRS or some other combination of measures) has expanded with clinically, culturally, and economically diverse clients. FIT's effectiveness has been impressive: feedback and routine outcome monitoring reliably increases the rate of clinically significant change, consistently decreases deterioration rates and dropouts from treatment, and significantly reduces the cost of mental health care (Lambert et al., 2018). Schuckard et al. (2017) noted that the costs increased in non-feedback groups. Questions remain, however. For example, is it simply the use of measures to assess outcome and alliance that contributes to improved treatment

outcomes, or does the process of engaging people in their own care produce the most improvement? Can you even have the second factor without the first?

Focusing too closely on the measures themselves comes with the risk of distracting from outcome (Miller, Duncan, & Hubble, 2004). One ~~dismantling~~ study found that using both alliance and outcome measures did not translate into any significant increase in feedback effects when compared to using just one or the other to solicit feedback (Mikeal, Gillaspy, Scoles, & Murphy, 2016). These findings suggest that the process of asking clients about their experience of therapy may prove more important than what is being asked (i.e. which measures are used to gather feedback). These findings also highlight the importance of developing a collaborative treatment culture that engages clients in dialog about the treatment process as well as the change process itself. Further, it points to a reality that can be unpleasant for clinicians and administrators to realize: In some cases, improving treatment skills and services can take years.

Therapy without both outcome and alliance feedback presents limitations. For example, opting to administer only alliance measures hinders the ability to track client progress along with valuable aggregate data, including session-to-session change. While studies to date have not proven which measure – alliance or outcome – actually makes the critical difference, it's virtually impossible to know if the client is making progress without using both. Using outcome measurement alone may limit insight into fluctuations

in the strength of the alliance, which hold predictive value in terms of engagement and retention.

Future Directions

There are three principal future directions for FIT. These are: 1) increased dissemination and implementation; 2) more investigation into understanding when FIT is and isn't effective, and 3) improving the deliberate practice of therapists in response to feedback and routine outcome monitoring. Given its evidence-base and portability into any therapist's practice, it is no wonder many psychotherapists are implementing formal feedback systems to monitor their clients' progress and experience of the alliance. Still, FIT continues to evolve and remains a relatively new approach. Not all mental health professionals are using routine outcome monitoring in their practices. Some are not familiar with FIT, while others are hesitant to implement FIT. In one such instance, Babins-Wagner (2017) presented research on the value of outcome and alliance measurement and found that only 60% of therapists in an agency opted to use the measures. When asked, therapists typically offer many reasons for this (Babins-Wagner, 2017). Objections such as "it will take too much time," "it will conflict with my style," or "my clients won't like it" too often prevent therapists from implementing FIT. Even when therapists administer feedback measures, they often don't act on the information they receive. As just one example, Lutz (2014) found that when the feedback suggests a client's condition is worsening, they do not discuss it with clients about 60% of the time.

Furthermore, therapists provide clients with other treatment resources only about 27% of the time. Studies have also found that therapists only adjusted therapeutic interventions 30% of the time, varying the intensity or dose of services 9% of the time, and consulted with others (for example, through supervision or education) about 7% of the time (Lutz, 2014; Miller, 2014).

While some mental health professionals have reservations about implementing formal measurement processes, 92% of people in health care say they like the use of outcome measures (Lutz, 2014). Thus, therapists' attitudes are more likely than clients to prevent full implementation of FIT. Such findings suggest a need to help therapists explore and resolve their reluctance to implement FIT. Ultimately, the goal of dissemination and implementation is not only to share the value and methods of FIT, but to ensure that it is conducted appropriately and that clients receive the most effective services.

As encouraging as it may have been when early evidence showed client feedback and routine outcome monitoring to improve therapy, recent studies have returned less robust results (Lambert et al., 2018). Chow (2017) notes that "ROM and feedback studies are not immune to the decline effect … earlier studies have demonstrated therapeutic benefits of using feedback measures, but more recent studies have shown contrary results" (Chow, 2017, p. 325). Several recent studies have produced evidence of this decline effect. Other methods for providing therapy have been susceptible to this effect. It

may result from several factors, including the enthusiasm and allegiance of its developers and early adherents, regression toward the mean in scientific studies, probable publication bias, and the lack of treatment fidelity in later studies (Maeschalck, Prescott, & Miller, 2019). Future researchers may wish to examine the boundary conditions of the efficacy of FIT more closely, including when, how, and with whom it works.

Concerned that on its own, feedback is not enough to produce acceptable, sustainable gains in therapy outcomes, Miller, Hubble, Chow, and Seidel (2013) have looked more closely at the emerging empirical consensus that therapist factors influence outcomes. "Available evidence documents that the therapist is one of the most robust predictors of outcome among factors studied. Indeed, the variance of outcomes attributable to therapists (5%–9%) is larger than the variability among treatments (0%–1%), the alliance (5%), and the superiority of an empirically supported treatment to a placebo treatment (0%– 4%)" (Miller et al., 2013, p. 90). They examined research literature on experts and expertise in fields such as music, medicine, and sports. This large body of research outside of psychotherapy provides clearer direction that can improve outcomes.

They concluded that the most common avenues to superior performance consist of three steps: (1) determining one's baseline level of effectiveness; (2) actively obtaining systematic, ongoing feedback on performance; and (3) engaging in deliberate practice to

improve outcomes. While this can seem simple when described in the pages of a book, it can require very significant effort.

Deliberate practice involves individualized activities especially designed to improve specific aspects of an individual's performance through repetition, reflection, and successive refinement. To achieve the maximum benefit from feedback, individuals have to monitor their training with active concentration on a regular basis (Ericsson & Lehmann, 1996).

FIT can enhance outcomes at two levels. First, it informs the work one client at a time. Second, aggregate outcome data informs the therapist about their level of effectiveness compared to national norms via their relative effect size. By establishing a baseline of performance, and by analyzing outcome and alliance data, therapists can identify weak spots and practice skills for professional growth and improvement. Deliberate practice includes creating and executing a plan for improving one's performance. The emerging research indicates that therapists with superior outcomes experience professional self-doubt. They are inclined to dwell less on their successes, focusing instead on what they don't do well and how they can do better (Chow, 2017). In fact, the most effective therapists spend, on average, two to three times more hours per week engaged in deliberate practice activities than other therapists do (Chow, 2017). Recent developments recommend deliberate practice as a clear pathway to improved therapeutic outcomes.

Contraindications/Critique

Research studies to date have not identified clinical contraindications, at least not in the traditional sense of a particular treatment being inappropriate for a certain condition. People generally like to be asked about their experiences and whether things are getting better for them. Rather than saying that there are some clients for whom FIT won't be effective, it is more likely that some practitioners are not a good match for FIT. As seen earlier in this chapter, there are a number of conditions under which FIT may not be wholly effective. At the same time, it can take practitioners years to become more effective as a result of being feedback-informed. Therefore, the greatest contraindications are when:

- Clinicians do not want to use FIT or use it half-heartedly.
- Clinicians are unable, unready, or unwilling to create a culture of feedback in their practice.
- Clinicians do not use the measures correctly or for the purposes intended.
- Clinicians do not act on the feedback they do receive (thereby communicating to the client that they are eliciting feedback only in a pro forma fashion).
- Clinicians are unwilling to engage in deliberate practice and use the feedback they receive for the purpose of improving services.
- Clinicians believe that their outcomes may be used against them.
- Practice settings/agencies are uninterested in being feedback-informed or are not invested in supporting clinicians in using FIT.

Societal Example

Placing all of the above information in a broader context, what can we learn about feedback's role in other circumstances, across society? And how can this shape our

responses to numerous circumstances within and outside of clinical work? To start, many readers will have had the experience of making a complaint to a business. When the business responded favorably and took some action to improve the situation, it is likely that we became more loyal or regular customers. In the authors' experience, this is something that many business owners know, and yet clinicians don't: when one gets a complaint and addresses it appropriately, that business gains a loyal customer.

Of course, getting meaningful and helpful feedback can be harder than it seems, which is why market research is a highly specialized business. Ask yourself: Have you ever been in a restaurant where the meal was less than perfect? When the server came over and asked the familiar question, "How is everything?" were you completely honest? Or did you simply want to resume your mealtime conversation? The way one asks for feedback matters, as does the broader spirit of inquiry.

At a broader level, FIT practitioners will begin to notice all the ways that feedback is there for the taking, if only we are all willing to listen to and act upon it. The implications for human interaction are profound; it often seems that people do not listen to one another with a goal of understanding nearly as much as they think.

Conclusion

Increasingly, it appears to the authors that professionals feel obliged to adhere to one therapeutic model or another. In many circles, it is common to hear people describe not only the clientele they treat but the methods they use (for example, "I treat trauma

survivors using EMDR"). Given the effort and expenses involved in learning particular models and techniques, this is perhaps unsurprising. However, it might also come with a different price tag: **In psychotherapy research and practice, one size never fits all.** As useful as deep immersion in specific models and techniques can be, FIT enables the individual therapist, working with diverse clients, to foster change and become more effective one client at a time.

Additional Readings/Resources/Websites

Miller, S. D., Hubble, M. A., & Chow, D. L. (2020). *Better results: Using deliberate practice to improve therapeutic effectiveness.* Washington, DC: American Psychological Association Press.

Prescott, D.S., Maeschalck, C.M., & Miller, S.D. (2017). *Feedback-Informed Treatment in clinical practice: Reaching for Excellence.* Washington, DC: American Psychological Association Press.

www.myoutcomes.com (web-based platform for using the ORS and SRS that offers real-time feedback, expected trajectories of progress, and a number of other features)

www.centerforclinicalexcellence.com (website for the International Center for Clinical Excellence, a platform for training as well as sharing resources and knowledge about FIT)

Activity

Before diving head first into FIT, you may wish to reflect on some key elements within it. For example:

Ask yourself how effective you are compared to your peers. Are you average? Are you better than or less than average?

What factors led you to arrive at your conclusion? Was it purely the percentage of your clients that appear to improve, or are there other factors that influenced your decision?

How effective are you at identifying clients that are getting worse while in treatment? Given how poorly clinicians fare in this area in the extant research, what confidence do you place in your response?

What part of your clinical sessions do you think you could improve in (for example, how you work with strong client affect, how you begin or close a session, work with a model, etc.)? What are some small steps you can take to improve in these areas?

What kind of coaching is available to you as you try to improve in the areas that you just identified?

Chapter Summary in Bullet-Point Form

- The therapeutic alliance is central to all bona fide forms of psychotherapy
- The client's perception and feedback about the alliance is more predictive of outcomes than the therapist's perception.
- Monitoring the client's experience of change, especially early change, is crucial to ensuring client engagement and, ultimately, a successful treatment outcome.
- FIT is an evidence-based practice that involves regularly collecting client feedback to measure the alliance and outcome, and discussing these areas with the client.

- Routinely monitoring client feedback about their experience and progress in therapy:
    - helps to inform and refine service delivery to best meet each client's needs thereby, improving the chances of positive therapy effects;
    - serves as an early-warning system for when treatment is going off-track as well as providing ideas about the best ways forward;
    - assists professionals in improving their skills at helping people; and
    - helps agencies to reduce the variability between clinicians with respect to their effectiveness.
- There are four core competencies in FIT. These include
    - Research foundations
    - Implementation
    - Measurement and reporting
    - Continuous professional development
- Clinicians often fail to identify clients at risk for premature termination and other negative outcomes.
- Two measures that can be used in FIT are the Outcome Rating Scale (ORS) and the Session Rating Scale (SRS).
- FIT practitioners work to build a "culture of feedback" with their clients.
- It is crucial to use measures of outcomes and the alliance in the spirit in which they are intended.
- Current FIT algorithms are based on over a million cases. These have been tested and found not to vary across major ethnic and minority groups.
- FIT involves *deliberate practice* to improve outcomes. Deliberate practice involves individualized activities especially designed to improve an individual's performance through repetition, reflection, and successive refinement

NCE-Style Test Questions

1) In FIT, the therapeutic alliance:

    a) Involves agreement on the goals and tasks of treatment as well as the nature of the relationship, in accordance with strongly held personal values.
    b) Means that the therapist has an excellent relationship with clients and their supervisors alike.

c) Is central to all bona fide forms of psychotherapy.
d) A and C only

2) A “culture of feedback” involves:

a) Firm but fair administration of positive and negative reinforcement to underperforming clinicians.
b) Ensuring that all players have a voice in team meetings
c) The client feeling free to discuss their experiences without retribution and with the hope of having an impact. (true)
d) Skillful use by the therapist of metaphors involving feedback loops

3) Research finds that when change in therapy is going to happen:

a) It mostly likely begins to happen early in treatment (true)
b) It most likely happens in response to open-ended questions
c) The client first needs to get worse before they get better
d) It occurs quickly

4) Deliberate practice involves:

a) Mindful awareness within agency settings
b) Individualized activities designed to improve performance (true)
c) Processing trauma slowly and deliberately
d) Deliberately discussing unsuccessful cases in individual and group supervision

5) Successfully eliciting client feedback:
a) Can require a fundamental shift in how one thinks about therapy and the roles of the client and therapist.
b) Can be more difficult to accomplish than it seems
c) Involves much more than gentle inquiries into how things are going in treatment.
d) All of the above (true)

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