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CHAPTER 4 IT IS MY FRIEND WHO SHOWS ME MY SHORTCOMINGS

**It is my friend who shows me my shortcomings;
client feedback as a guide for treatment**

Flip Jan van Oenen

MGv, 2011, 66, 120 - 135

If people go to a psychotherapist, there is no guarantee that it will help. However good the therapy, success depends entirely on the relationship between the client and the therapist: is there a click, or not? It is time to listen to the client.

Background

Since psychotherapy began, psychotherapists have been trying to identify the therapies that are most effective and the factors that have an effect in the various types of therapy (for example, Rosenzweig, 1936; Eysenck, 1952; Lambert & Bergin, 1994; Wampold et al., 1997). The last fifty years have produced a wealth of research data about all kinds of psychotherapy (Wampold, 2001). Different conclusions can be drawn from the findings.

First of all, there are now about 250 therapy models, several dozen of which at least can be described as 'evidence-based practice' (EBP) (Lambert, 2001). The good news is that the debate about *whether* psychiatry has an effect has been settled: a plethora of studies have shown that it does (including Cuijpers et al., 2008; Wampold, 2001; 2007)¹. In the majority of cases, clients benefit from therapy or, in more precise terms: the average client who receives treatment is better off than 80% of the untreated group (Duncan et al., 2010). This means that psychotherapy is an effective instrument, and in any case just as effective as many 'evidence-based' interventions in medical practice, such as the use of beta blockers, asthma medication and flu vaccines.

The bad news is that, despite all the research, there is no evidence that psychotherapy has become more effective since the introduction of evidence-based practice (Wampold, 2001). And comparative research has shown that the differences in effects are small or negligible (Caraballo, 2008; Imel et al., 2008; Wampold, 2001).

An interesting thought, incidentally, is that the idea that all models work equally well is not at all new. As early as 1975, Luborsky et al. published an article to that effect in which, referring to *Alice in Wonderland*, they pronounced the 'Dodo verdict' on psychotherapy.²

Therapeutic factors: the alliance

Furthermore, despite all the research, hardly anything is still known about how and why psychotherapy works (Duncan et al., 2010). Only a very small tip of the veil has been lifted

¹ These articles are thorough meta-analyses that take a critical look at the quality of the sources analysed.

² The Dodo in Lewis Carroll's story is asked to pick the winner of a race in which all the animals have run around in all different directions. The Dodo decision is that 'Everybody has won and all must have prizes!'

on specific therapeutic factors in psychotherapy. The current situation is that most of the therapeutic effect remains unexplained and is linked to client variables. Lambert and Bergin (1994) established the following broad categories: 40% is due to client variables (severity of the disorder, level of social support, age, etc.), 15% to hope/placebo effect, 15% to the therapy method and 30% to the therapeutic alliance.

Wampold (2005), on the basis of wide-ranging meta-analyses, came up with even more extreme figures: 87% is determined by client variables, 13% by therapy variables. He breaks down these therapy variables into model-rated, therapist-related and alliance-related categories. His meta-analyses show that the model has little importance: only 1%. The therapeutic alliance, on the other hand, accounts for 8% and so it is actually 8 times more influential than the model; this means that the therapeutic alliance is the main known effective variable in the therapeutic process (Baldwin et al., 2007).³

Although the veil still conceals a great deal, what we can see is still very exciting. Because even if we take into account the fact that these figures probably still don't represent the definitive picture – research in this area remains challenging – we can certainly say that this finding contains a disconcerting message for the therapist: 'Forget about the model; it's the relationship, stupid!' So we would be better advised to invest our energy in improving the therapeutic relationship rather than designing and providing training for models and techniques. However, this paradigm shift has not yet gathered many adherents. On the contrary, the demand for an evidence base for the ongoing flow of new and 'improved' models has simply gone on increasing due to the influence of the scientific approach and the market philosophy.

However, this approach would seem to be driving the psychotherapist ever further way from the one thing that can help him: the unique, personal, working relationship with the individual client. The curious thing is that, in practice, few psychotherapists will disagree that the therapeutic relationship and their own personal role in that relationship are at the heart of their work. Indeed, it would seem to be the case that many therapists still derive their job satisfaction mainly from this component. That is why the central focus of practice-based manuals is often the art of developing and maintaining a working relationship with the client, the 'alliance' (Van Oenen et al., 2007).

³ One might question here whether the effect of the alliance is not a derivative of the effect of 'early change' (Hammond, 2010). It would now seem to be clear that the alliance is an important independent factor affecting the outcomes of therapy rather than a result of satisfaction with the prior results achieved (Baldwin et al., 2007; Anker et al., 2010).

Research looking at the question of which variables explain the quality and strength of the alliance between the client and the therapist has shown that this is apparently a complex phenomenon in which characteristics of the treatment process, the therapist and the client interact (Anderson et al., 2009; Duncan et al., 2010; Norcross & Lambert, 2005).

A major publication by a Task Force of the APA (Castonguay & Beutler, 2006) made an attempt to classify all the therapeutic factors but did not get any further than a list of very general factors that should, in effect, apply to any bona fide therapist: empathy, flexibility, a search for consensus and so on.

The question is: how can we exploit the knowledge that a good alliance makes a major contribution to treatment outcomes in order to achieve the best results?

Working with the Client Directed Outcome Informed approach

To answer this question, the Institute for the Study of Therapeutic Change in Chicago led by the psychologists Scott Miller and Barry Duncan developed an approach which assumes that monitoring the alliance between the client and the therapist allows for the early identification and restoration of a weak alliance (Duncan et al., 2004)⁴.

They describe this approach as 'Client Directed Outcome Informed' (CDOI) or 'Feedback Informed Treatment'⁵ It provides an instrument that makes it possible to evaluate the alliance systematically: the 'Partners for Change Outcome Management System' (PCOMS) (Miller et al., 2005), which is known in Dutch for short as the 'Beterwetermeter'.⁶ This method also describes the extent to which the approach leads to the outcome desired by the client. The approach is very pragmatic and it focuses on two variables: the alliance and the result achieved. The underlying idea is based on the following three principles.

'Handing over the helm'

In Feedback Informed Treatment, it is axiomatic that the best sailors hand over the helm. This principle is based on a number of research findings indicating that the client's own role is crucial for the success of a therapy: most of the change during therapy (87%) results – as was

⁴ Several routine outcome management systems, such as the OQ45 and the CORE-OM systems, have been developed that generate continuous feedback. However, the Beterwetermeter is the only tool that uses information in a 'directive' way and generates scores for both the alliance and well-being.

⁵ The developers originally named this approach 'Client Directed Outcome Informed'. Further on in this thesis the approach is indicated as 'Feedback Informed Treatment', since this term refers to a broader use of feedback.

⁶ This name was introduced by the author to the Mentrum Crisis Intervention and Brief Therapy team.

pointed out above – from the client's own role and extra-therapeutic factors. Clients learn different things from the therapy than therapists think, clients actively transform the therapy elements that are offered, and the client's impression of the alliance is a strong predictor of the success of the therapy, whereas the therapist's impression has much less predictive value (Bohart & Tallman, 2010).

The practical consequence is that the therapist should adopt the problem and the solution strategy – the 'theory of change' and 'preferences' – that the client puts forward as the guiding principles for the treatment plan rather than, as often happens, focusing on what he thinks is 'really' going on with the client. He then looks at the objectives and resources that the client thinks will help, and at the role the client expects from the therapist: an explorer, consultant or expert. This results in a treatment plan in consultation with the client.

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An approach in which the *judgement of the therapist* is central:

A. comes to the therapist feeling depressed. He says that problems at work are the main cause: his boss is constantly on his case. He wants to find practical solutions to that problem. And he wants the therapist to help him.

The therapist has the impression that other factors play a role, such as a depression, the client's personality, the reactivation of old problems and a conflict with his family. He stresses that pharmaceutical treatment and an understanding of the underlying problems are important and that short-term approaches to resolving symptoms using practical solutions will probably not make the client feel less depressed. He prescribes anti-depressants and suggests discussing the separation issues first with A. A. admits that those problems are still bothering him and says he will think about it. Without saying why, he does not turn up for the next appointment.

An approach in which the client's *theory of change* plays a central role:

A. comes to the therapist feeling depressed. He says that problems at work are the main cause: his boss is constantly on his case.

The therapist suggests that other problems may also play a role, but that he would like to work together with A. to see whether addressing the problem at work could provide some relief. A. would like some advice about how he can more assertive in his dealings with his boss. The therapist discusses the problems at work, does some role play with A. and gives him

some tips. After a few sessions, A. says that he is now more confident in his dealings with his boss and is satisfied with the progress he has made. But his mood is still depressed. The therapist says that he would like to work with A., if A. thinks that is a good idea, to see if there are other factors that A. would like to talk about. Medication may also be a useful option. A. says he will think about it. A. calls back a few days later. He's not ready for medication yet but he would like to make an appointment to discuss some things that are bothering him.

'Setting sail together'

It is often said that a good ship needs a good crew. Since the quality of the alliance as perceived by the client is an important predictor of the success of the therapy (Miller et al., 2004; Anker et al., 2010), the therapist constantly asks systematically and in formalised ways for feedback about the quality of the alliance. This allows the therapist to develop and maintain the best possible alliance.

'Let's see where the tide takes us'

In addition to the alliance, a lack of improvement in the early stages is the second important predictor of poor treatment outcomes. It has been found that, when there has been no improvement after a few sessions, there will probably be none during the rest of the treatment (Miller, 2004; Lambert, 2007). That is why the therapist will regularly discuss the results – or lack of them – in a systematic way with the client and, on the basis of this feedback, make changes in the therapy on the basis of the feedback or refer the patient to a colleague (Baldwin, 2007).

In this context, it is interesting to note that Lambert (2007) has found that a lot of the time and energy of therapists – and therefore the money of the insurer and the client – is spent on the relatively small group of unsatisfactory treatments. He concludes that 90% of clients (in a 'college counselling' setting) terminate the treatment within 15 sessions but that the remaining 10% account for as much as 30 to 40% of the total number of contacts. These stagnating therapies generate a lot of client frustration, demand a lot of unproductive energy from the therapist and cost the insurer a lot of money.

It turns out that therapists who use formalised feedback from clients obtained with Feedback Informed Treatment achieve results that are significantly better than those achieved

with the clients when they do not use feedback (Anker et al., 2009; Miller et al., 2006; Reese et al., 2009).⁷

It should be pointed out here that Feedback Informed Treatment can also be valuable for practitioners who are not convinced of the need for this re-orientation. They are also more effective if they use feedback to monitor the alliance (Anker, 2009).

Session Rating Scale and Outcome Rating Scale: implementation in practice

The details of working with Feedback Informed Treatment are as follows. Satisfaction about the alliance and the therapy is measured with simple scoring lists that take little time to complete. The 'Outcome Rating Scale' (ORS) (Miller et al., 2003) and the 'Session Rating Scale' (SRS) are used (Duncan et al., 2003).

The 'Outcome Rating Scale', in Dutch the 'Hoe gaat het met u?' form, scores client assessments of various areas of their functioning and it is completed at the start of the session. It consists of one A4 form with four lines (*visual analogue scales*) each of which relate to one aspect of client well-being: 'individual', 'relational', 'social' and 'general' (see Figure 1).

⁷ Miller et al. (2006) found that using Feedback Informed Treatment reduced the risk of drop-out by a factor of three and that results improved by a factor of two. Anker et al. (2009) found that, in couple therapy, the desired goals were achieved significantly more often and that the divorce rate was a lot lower in the FIT group. Reese et al. (2009) found that clients improved more and faster when FIT was used.

Figure 1: Outcome Rating Scale

How have you been this past week, or since the last treatment contact, including today?
Put a cross on each line.
'Not well' is on the left and 'well' is on the right.

Individual
(personal well-being)

|-----|

Relational
(family, close friends)

|-----|

Social
(work, education, social contacts)

|-----|

General
(general well-being)

|-----|

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The clients were asked to place a cross somewhere on each line as an assessment of their functioning in the period prior to the session. The far left of the line is 'poor'; the far right is 'good'. On a line measuring 10 cm, this results in a score between 0 and 10.

The 'Session Rating Scale', in Dutch the 'Hoe vond u de bijeenkomst?' form, measures various aspects of the alliance and it is completed at the end of the session. This is also a single form with four lines that works in the same way as the ORS form. It looks at four aspects of the treatment session: the relationship, the goals, the approach and the session as a whole (see Figure 2).

Figure 2: Session Rating Scale

Put a cross on each line for the description that best fits your feeling

I felt I was *not* listened to, understood or respected.

Relationship

I felt I was listened to, understood and respected.

|-----|

We have *not* been working on or talking about the things I wanted to work on or talk about.

Goals and subjects

We have been working on or talking about the things I wanted to work on or talk

|-----|

Approach

The therapist's approach was *not* right for me.

The therapist's approach was right for me.

|-----|

There was something missing from the contact during the treatment today.

General

Overall, the contact during the treatment today was good.

|-----|

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The questionnaires, which are also available in versions for children, are completed and discussed at every session. This discussion can be minimal or extensive depending on the information obtained.

When the crosses on the SRS form indicate reticence or simple dissatisfaction, questions are always asked about the subject of dissatisfaction. Relatively limited criticisms can be discussed immediately. With structural comments or criticisms, it is best to make an appointment to discuss them at length during the following session, at least once a check has been made to see whether there is enough trust on the client's side to ensure that the client will be there next time.

Interpretation and implications of the score

The ORS form is discussed briefly at the beginning of the session. When a change is evident compared to the previous session, the discussion looks at the significance of that

change. Is there a relationship with the treatment sessions or is there a life event that is having a strong influence on well-being at this point?

During the initial sessions, it is important for there to be an improvement (or at least a mild improvement) because, as was pointed out above, the absence of any improvement is an important predictor of therapy failure and drop-out. In the slightly longer term, the ORS form is an indicator of the perceived effect of the treatment as a whole and, in combination with the SRS, it provides a timely indication of any stagnation in the treatment. A low score on the SRS form may indicate client doubts about the alliance. This need not be a problem when the ORS form indicates that well-being is improving. Some 'conflict' may even be beneficial: the best results seem to be achieved when there is initially some expression of dissatisfaction with the alliance and when the appraisal of the alliance gradually becomes more and more positive (Anker, 2010). The most important thing seems to be a positive development in the alliance; an SRS score that remains low will result in drop-out within the foreseeable future.

When a low ORS score fails to rise after a few sessions despite attempts to adapt the treatment to the wishes of the client, the case should be discussed in intervision/supervision or a colleague should be consulted. If better scores still fail to materialise after about seven sessions, referral to another therapist is the appropriate option. Persisting after that point results in frustration on both sides and a waste of time and money.

It is important that the therapist does not interpret critical feedback as a personal failure. He should accept it gratefully: feedback will help him to be a more effective therapist. In addition, if the treatment stagnates, he should not see this as a defeat but rather as a timely recognition of the stagnation and careful referral as a reflection of his own qualities. As the old saying goes: 'It is my friend who shows me my shortcomings'.

'You can't marry everyone you date'

A relationship needs a 'click' and that isn't always there. Lambert (2007) finds that, on average, 35 to 40% of clients fail to make progress in therapy and that 5 to 10% deteriorate; even the best-performing therapists are successful with only 44% of their clients and the therapists with the lowest performance scores achieve success in only 28% of cases. So it is not so important to strive for a perfect match with everyone; what mainly matters is to intervene in good time when there is a mismatch. This does not mean that somebody is being 'sent away': the therapist stays in contact and helps to find another therapist who matches the client better.

For example, when satisfaction with the alliance is high (high SRS scores) but when there is no improvement or no more improvement in the ORS score, this is an indication that steps should be taken to change the treatment; if there is a slight increase, longer intervals between the sessions may be one option. A persistent combination of a high score for the alliance and a low score for changes in well-being can be seen as the numerical expression of an unproductive dependent relationship.

Various applications possible

Because developing and maintaining the therapeutic relationship is a component of every form of therapy, Feedback Informed Treatment can be used in addition to every therapy model, be it cognitive, psychodynamic, system-based or with any other orientation. The therapist can continue to use his own individual psychotherapy method; no extensive training in other models is needed. This type of formal feedback is now used for, among other things, addiction problems (Bohanske & Franczak, 2010), family and relationship therapy (Anker et al., 2009) and individual psychotherapy (Reese et al., 2009; Hafkenscheidt, 2008) and it is certainly not restricted to 'milder' problems.

The forms can be used in different ways in different settings.⁸ In a clinical setting, the client can, for example, complete them on a weekly basis to evaluate the outcomes of the admission. In children, the ORS form can generate a lot of direct information about their perceptions due to the open approach in the form, with no emphasis on pathology. It can also identify clients who feel they are being 'controlled' because they will generally enter higher ORS scores than might have been expected. A therapeutically interesting possibility is to ask the client to complete the ORS form in the way that the person making the referral (the probation officer, for example) would have completed it for the client. This can generate a therapeutic perspective: how can the therapist help the client to ensure that the person making the referral will change his 'misplaced' judgement?

Information of interest can also be obtained in system therapy by working together during the session to compare the SRS form and the ORS scores of the various system members. Different ORS scores from system members can, in this way, bring to the fore undiscussed differences in the burden of disease. Differences between SRS scores can reveal that some system members did not feel they were being listened to as much as others during

⁸ There has not yet been any systematic description of how to use the forms in different settings.

the session. Open discussion of the scores can make these differences clear and amenable to discussion.

It is, of course, also possible to create a 'feedback culture' without scoring lists; the scoring lists are an instrument, not an end in themselves. Most therapists will also try to monitor developments of this kind without forms and to discuss them in good time. However, practice has demonstrated that clients will not usually signal dissatisfaction until it is too late. It is like being in a shop where you feel nobody is helping you properly: you are more likely to leave and not come back than to take the trouble to complain. The added value of the formalised feedback is that it is possible to find out in good time when clients feel they are not being helped properly.

Experience with the method

Some large institutions in the US now use the method, and it is already being used quite extensively in Norway and Sweden. Therapists have now been using the method in an increasing number of locations in the Netherlands for a few years.⁹ The Dutch translation of the forms was introduced by Hafkenscheidt in 2000, who found, in a pilot study conducted recently (Hafkenscheidt, 2010), consistent values for both lists, indicating that the lists are a reliable measure.¹⁰ The Mentrum Crisis Intervention and Brief Therapy has been working with the method since 2007; a randomised controlled trial is now being conducted there to determine the effect of the method in a naturalistic psychiatric setting.

My own experience is that Feedback Informed Treatment will generally be seen as a fairly natural extension of the repertoire by people who are already using feedback-oriented methods; a change in attitude is required from therapists who are not used to asking clients directly what they think of the therapy. In any case, the method requires a willingness on behalf of the therapist to place himself in a vulnerable position. This proves to be daunting for many therapists initially but they are often pleasantly surprised because most feedback by far turns out to result in positive reflection. Furthermore, therapists often have reservations initially because they wonder whether therapy will not end up being a question of 'the customer is always right' and whether they will have to have many more methods in their

⁹ For example in emergence psychiatry (Mentrum), long-term psychotherapy (Sinai Centre), youth care (Kentalis and Trias Youth Services), out-patient care (Molemann) and by a growing number of independent therapists (Mentaal Beter).

¹⁰ The translated forms can be downloaded free of charge from the websites of Duncan (www.heartandsoulofchange.com) and Miller (www.scottdmiller.com). Payment is required to use the digital version.

repertoire since each client will require a different approach. Experience has shown that this is not the case. Therapists can continue to fall back on their own preferred frameworks as long as they check whether this approach is appropriate for the client (and continues to be so). In practice, clients don't ask for completely different approaches but for gradual adjustments that often relate more to the personal approach to implementation adopted by the therapist than to the method itself.

The method also requires some degree of humility: the realisation that all therapists can't help all clients. However, when therapists are able to understand that an early acknowledgement of the fact that a good match has not been established is not a sign of incompetence but precisely of a professional approach, this can be felt to be liberating.

Finally, an important pre-condition to ensure that therapists can apply the method without restrictions is that scores should not be used to hold therapists to account. Because as soon as management or health insurers start to use the instrument to identify therapists who are not performing as well and to use the scores as a basis for sanctions, therapists and clients will no longer feel free to discuss the feedback honestly and openly. That will sound the death knell for the method because its strength is precisely the creation of an open culture of feedback.

The future

The model-oriented, evidence-based approach of the past few decades has so far failed to generate any added value for the further development of quality in psychotherapy. The introduction of more therapy models and more guidelines with protocols in recent years has not made psychotherapy more effective. In addition, only limited progress has been made in terms of identifying therapeutic factors. In this respect, cognitive behaviour therapy is an illustrative example in which the model has shifted from 'changing behaviour', via 'changing cognitions' and 'accepting cognitions', to 'letting go of cognitions' (with the *mindfulness-based* approach now occupying a prominent position) and there may be reasonable doubt about whether cognitions are even the active therapeutic element in the approach (Jacobsen et al., 1996).

An outcome-oriented approach like Feedback Informed Treatment generates concrete opportunities to improve the outcomes of therapy: by collecting immediate feedback about the alliance and the outcomes of the treatment in systematic ways, major gains can be made with respect to improving well-being, drop-out rates and efficiency. And continuous evaluations of

the therapy based on client experience mean that the method ensures that client perceptions really are central.

Management and health insurers will also be in favour of the widespread application of Feedback Informed Treatment since it can improve results and the efficiency of treatment. However, there is a major risk here. As was pointed out above, the method can only be used successfully if the therapist feels secure enough to open up to criticism. Health insurers in particular will be sorely tempted to use the scores as quality benchmarks. And however appealing it may be to use the scores to make it public which therapists or institutes are scoring well or not, this will inevitably lead to therapists feeling exposed and to the manipulation of the scores. Health insurers should therefore not be allowed direct access to the actual outcomes; they can encourage therapists to use feedback methods. There is therefore every reason to switch from a model-oriented to an outcome-oriented approach: from evidence-based practice to practice-based evidence (Miller et al., 2006).

It is hoped that further scientific study of the data collected by systematic feedback will shed even more light on the therapeutic factors in psychotherapy. For the time being, therapists will have to accept that they can be more successful only by recognising their failures in good time.

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