INTRODUCTION

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In a scenario with themes familiar to many, Eddie was 17,[1] had an extensive history of trauma, and was tentatively diagnosed on the autism spectrum. He had been removed from his abusive family several years earlier and placed with an aunt who became his guardian. She referred him for treatment because of concerns about explosive and aggressive behavior. These behaviors reflected both his trauma history and his difficulty in interacting with the world around him.

Uncertain about the nuances of relationships, Eddie made it clear that he considered his relationship with his therapist, Bill, to be exclusive and wanted as little information as possible shared with his guardian. Bill had no misconceptions about the tenuous nature of his working alliance with Eddie, and he used measures described throughout this volume to monitor outcomes

[1]In this case example, and in all examples discussed in this book, proper steps were taken to ensure client confidentiality.

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related to overall well-being as well as the alliance. He used these measures routinely on a session-by-session basis and used the feedback he received to work at becoming an even more effective therapist.

One day, Bill made what he considered a "rookie mistake." When Eddie arrived escorted by his guardian, Bill asked to speak with her about a matter related to Eddie's health care insurance, which led to the guardian offering to share a previous psychological evaluation report that Bill had not seen. By the time Bill finished the conversation a few minutes later, Eddie had become quiet, made poor eye contact, and participated minimally in the session. It was easy to assume that Eddie was frustrated because Bill had not respected the exclusivity of their work together. Bill wasn't entirely sure that this was the case because Eddie would not tell him what had happened.

Reflecting on the situation, Bill did as he often did before sessions: He examined the trajectory of scores on Eddie's outcome measure as well as a scale related to the therapeutic alliance. The changes in these numbers told him that treatment seemed to be becoming less helpful, and his alliance with Eddie was indeed in serious trouble. It wasn't just that Eddie was less communicative; the problem was that Bill had unwittingly destroyed the "culture of feedback" he had worked so hard to create with Eddie. Further, Eddie was not improving on certain global outcomes (e.g., his personal sense of well-being; his relationships with others at school and in the community; and his relationships with people close to him, such as his guardian).

Bill was aware that in the past, he might have simply persisted in trying to be helpful to Eddie. He might have even told himself that he had faced similar challenges before and had been able to address them for the most part and that there was nothing to worry about. Now that he had actual measures to review on a session-by-session basis, he became acutely aware that whatever his self-assessment of his abilities might be, Eddie was getting worse when he should have been getting better and that he no longer had a relationship in which Eddie was willing to speak openly about their work together. It was time to return to the basics of the therapeutic alliance with Eddie. Bill needed to work in a deliberate fashion to accept responsibility for his contributions to the situation and make adjustments to their work accordingly.

Bill's experience with Eddie serves as a reminder of therapeutic principles that often go undiscussed in our work. Underneath all of our clinical practices—indeed, all helpful interactions—lies a particular kind of conversation. Our field is replete with examples of how professionals should speak and be with clients. This can be a source of great fascination, from the earliest authors, through Carl Rogers's core conditions, Berg and de Shazer's focus on the seemingly simple search for solutions, and beyond. Wampold and Imel (2015) referred to the conversation as "perhaps the ultimate in low

technology" (p. ix), and Miller and Rollnick (2013) described their work with motivational interviewing as "something done *for* and *with* someone, not *on* and *to* them" (p. 24, italics in original).

Obviously, not all conversations are helpful, even as they are central to all bona fide forms of psychotherapy (Wampold & Imel, 2015). What was central to Bill's assessment of his failure reflects research findings on the therapeutic alliance (Duncan, Miller, Wampold, & Hubble, 2010; Hubble, Duncan, & Miller, 1999). That is, that the most helpful clinical practice takes place when there is agreement, from the client's perspective, on the nature of their relationship, the goals of their work, and the means by which they go about it. This view of the therapeutic alliance dates back decades (Bordin, 1979), although research has also emphasized the importance of delivering treatment in accordance with strong client values and preferences (e.g., Norcross, 2010). Indeed, the importance of the alliance has long been recognized (Orlinsky & Rønnestad, 2005).

Although the therapeutic alliance is central to clinical practice, it is not the only consideration. Without attending to the outcomes (e.g., whether a client's condition is improving, worsening, or staying the same), there is no way to know whether we are helping clients meet their goals.

This book provides insight into how various mental health professionals (individuals and agencies alike) have worked to become more effective. It includes case examples of success, failure, and "failing successfully" (i.e., recognizing when treatment isn't working and negotiating alternatives). The framework guiding this work is feedback-informed treatment (FIT). FIT is a pantheoretical approach for evaluating and improving the quality and effectiveness of behavioral health services. It does not demand that one throw out models and techniques that work with specific clients, although readers may come to view those approaches differently and rethink practices that don't benefit clients. However, it does involve routinely and formally soliciting feedback from consumers regarding the therapeutic alliance and outcome of care using empirically validated measures and using the resulting information to inform and tailor service delivery (Bertolino & Miller, 2013, p. 4).

Bill's use of the Outcome Rating Scale (ORS; Miller & Duncan, 2000) and Session Rating Scale (SRS; Miller, Duncan, & Johnson, 2000), two measures that can be used in FIT, served as an early warning system that alerted him when treatment was not progressing and was in fact unhelpful. Referring to the data that these measures provide helped Bill to see key indicators of the alliance and outcomes of treatment more clearly than he might have under more traditional circumstances. FIT principles (namely, the importance of providing a culture of feedback and embarking on a plan of deliberate practice to improve his outcomes) also guided him into a more

helpful direction, one in which he could more effectively keep his biases about himself and the client in check. Indeed, the combination of these measures and their focus on outcomes and the alliance allowed Bill to be a true partner in change.

The idea of routinely monitoring one's outcomes is not new (Lambert, 2010). However, selecting the right measure can be intimidating. Ogles, Lambert, and Masters (1996) reviewed available tools and found more than 1,400 measures had been used to determine the effectiveness of psychotherapy. Most of these measures were designed for the purpose of research or as part of a comprehensive evaluation. Brown, Dreis, and Nace (1999) observed that measures or combinations of measures that require more than 5 minutes to complete, score, and interpret will typically not be considered feasible by the majority of clinicians. Measures that are user-friendly and provide real-time feedback are therefore all the more important when one considers the often urgent circumstances in which clients and treatment providers exist. This volume considers a variety of outcome and alliance measures (e.g., Chapters 3, 7, and 8).

Even with the right measures, questions remain about meaningful implementation (see Moss & Mousavizadeh, Chapter 5, this volume) and professional improvement (see Chow, Chapter 16). These questions provide much of the impetus for this book. What is the best use of the available measures and methods for outcome monitoring? How can practitioners create an environment where feedback, improved outcomes, and professional growth thrive? What can practitioners learn about themselves and their clientele through FIT? What reliable steps can practitioners take to improve their performance? How do practitioners know when they are getting better? Most practitioners reach for excellence; not all succeed. Research has found few effects of experience or training on improving clinical outcomes (Goldberg et al., 2016; Wampold & Brown, 2005). If there is any lesson from this book, it is that the simple use of routine outcome monitoring alone does not improve practitioners' performance. Going from good to great requires the specific pursuit of *deliberate practice* (see Schuckard, Miller, & Hubble, Chapter 1, and Chow, Chapter 16, this volume).

Deliberate practice is a focused, specific form of hard work. Deliberate practice is far from being inherently and consistently enjoyable, however much the editors of and contributors to this volume might wish it were otherwise. Still, it is vital to bear in mind in an era when new methods for assessment and treatment appear to offer both promise and allure that just as changing one's life in treatment is never easy, neither is becoming an effective agent of change. The obvious payoff of deliberate practice is in performance, although other benefits can appear as a result, such as an improved learning style and, of course, better outcomes.

Part I of this volume examines FIT in theory and general practice. Eeuwe Schuckard, Scott D. Miller, and Mark A. Hubble begin with a chapter on FIT's historical and empirical foundations (Chapter 1). They begin with a well-established but uncomfortable fact: Despite the time, energy, and money expended in many projects aimed at improving psychotherapy, research shows that the majority of such initiatives have failed to improve either the quality or outcome of care. David S. Prescott next presents FIT's basics and core competencies (Chapter 2), reviewing four core areas of competence: research foundations, implementation, the use of relevant measures and reporting, and continual professional development. He also reviews many barriers to collecting feedback that practitioners might encounter. Cynthia L. Maeschalck and Leslie R. Barfknecht explore how to generate and use client feedback to inform treatment (Chapter 3). They review psychometric properties of the ORS and SRS and offer numerous ideas for analyzing the data generated by these measures. Next, Susanne Bargmann discusses the use of FIT in clinical supervision (Chapter 4) and suggests a model for FIT supervision. Randy K. Moss and Vanessa Mousavizadeh conclude this part of the book with a chapter on FIT implementation. They argue that implementing FIT is not simply an event but an ongoing process that moves between distinct stages, often in a nonlinear manner.

Part II explores FIT in specific practice areas. The authors of these chapters offer guidance based on their own experiences implementing FIT in various domains. They present their successes as well as the challenges they faced as lessons for other practitioners who want to integrate FIT into their own work. In Chapter 6, Jason A. Seidel opens this section with a direct, almost unorthodox chapter outlining tips for private practitioners via his personal advice and professional experience. He describes not only the hard work but also the personal and professional rewards of becoming truly feedback-informed. Next, in Chapter 7, Robert L. Gleave and colleagues describe FIT in group treatment settings. They offer explicit advice in using the Outcome Questionnaire—45 and Group Questionnaire and provide findings from their practice and offer implications for practitioners. In Chapter 8, Robbie Babins-Wagner discusses FIT in agency and clinic settings and the painstaking work that her Canadian agency did to improve its outcomes. In Chapter 9, Bob Bertolino summarizes a decade of experience with FIT in an agency serving children, youth, and their families. He describes starting by aligning his agency's mission with the values underlying FIT and eventually producing better lives for many clients. Bill Robinson explores the use of FIT in couples counseling in Chapter 10. A seasoned therapist, Robinson describes how FIT can be used with typical cases in a community-based practice. Julie Seitz and David Mee-Lee discuss FIT in the treatment of substance abuse in Chapter 11, recounting the evolution of their

agency and practice with information about implementation and individual cases. Chapter 12, by Brittney Chesworth and colleagues, explores the importance of FIT with LGBTQ clients. The chapter provides critical information about working with this population that all practitioners should know, along with recommendations for how FIT can improve clients' lives. David S. Prescott discusses FIT with forensic clients in Chapter 13. His chapter focuses on what professionals need to know when practicing in this arena and provides a handful of in-depth examples. In Chapter 14, Ryan Melton and Elinor Taylor explore FIT with early-onset psychotic disorders. They provide actionable knowledge about this population and include the voices of many of their clients as guideposts for professionals working with this vulnerable clientele. Janice Pringle and Jaime Fawcett conclude Part II with a discussion of FIT in the context of medication adherence. They observe that most cases of inappropriate medication use involve whether and how patients take their medications. By facilitating (rather than compelling) patients' behavior change, practitioners can help them take medications as prescribed.

Part III focuses on professional development and the pursuit of excellence. It contains a chapter by Daryl Chow with the self-explanatory title "The Practice and the Practical: Pushing Your Clinical Performance to the Next Level." Chow emphasizes how and why routine outcome monitoring on its own is not enough to improve performance. After describing the characteristics of excellent therapists, he then explores deliberate practice, a central element of FIT. This chapter ties together many of the themes emphasized throughout the preceding ones.

This book is for people who want to become excellent practitioners and are willing to look at and work on themselves along the way. It is aimed primarily at professionals in the mental health fields, such as psychologists, social workers, and others interested in psychotherapy and specialized areas such as substance abuse treatment, medication adherence, and the like. Students who read these chapters will learn that their work can provide benefit every bit as much as more seasoned professionals. It is our hope that this book inspires practitioners and gives researchers ideas for areas of further study. FIT provides a practical means to determine effectiveness, inform our work, and guide us on the path toward excellence.

REFERENCES

Bertolino, B., & Miller, S. D. (Eds.). (2013). *The ICCE feedback-informed treatment manuals* (Vols. 1–6). Chicago, IL: International Center for Clinical Excellence.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research, & Practice*, *16*, 252–260. http://dx.doi.org/10.1037/h0085885

Brown, J., Dreis, S., & Nace, D. K. (1999). What really makes a difference in psychotherapy outcome? Why does managed care want to know? In M. A. Hubble, B. L. Duncan, & S. D. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 389–406). http://dx.doi.org/10.1037/11132-012

Duncan, B. L., Miller, S. D., Wampold, B. E., & Hubble, M. A. (Eds.). (2010). *The heart and soul of change, second edition: Delivering what works in therapy*. Washington, DC: American Psychological Association.

Goldberg, S. B., Rousmaniere, T., Miller, S. D., Whipple, J., Nielsen, S. L., Hoyt, W. T., & Wampold, B. E. (2016). Do psychotherapists improve with time and experience? A longitudinal analysis of outcomes in a clinical setting. *Journal of Counseling Psychology*, *63*, 1–11. http://dx.doi.org/10.1037/cou0000131

Hubble, M. A., Duncan, B. L., & Miller, S. D. (Eds.). (1999). *The heart and soul of change: What works in therapy*. http://dx.doi.org/10.1037/11132-000

Lambert, M. J. (2010). *Prevention of treatment failure: The use of measuring, monitoring, and feedback in clinical practice*. http://dx.doi.org/10.1037/12141-000

Miller, S. D., & Duncan, B. L. (2000). *The Outcome Rating Scale*. Chicago, IL: International Center for Clinical Excellence.

Miller, S. D., Duncan, B. L., & Johnson, L. J. (2000). *The Session Rating Scale*. Chicago, IL: International Center for Clinical Excellence.

Miller, W. R., & Rollnick, S. (2013). *Motivational interviewing: Helping people change* (3rd ed.). New York, NY: Guilford Press.

Norcross, J. C. (2010). The therapeutic relationship. In B. L. Duncan, S. D. Miller, B. E. Wampold, & M. A. Hubble (Eds.), *The heart and soul of change, second edition: Delivering what works in therapy* (pp. 113–141). http://dx.doi.org/10.1037/12075-004

Ogles, B. M., Lambert, M. J., & Masters, K. S. (1996). *Assessing outcome in clinical practice*. Boston, MA: Allyn & Bacon.

Orlinsky, D. E., & Rønnestad, M. H. (2005). *How psychotherapists develop: A study of therapeutic work and professional growth*. http://dx.doi.org/10.1037/11157-000

Wampold, B. E., & Brown, G. S. J. (2005). Estimating variability in outcomes attributable to therapists: A naturalistic study of outcomes in managed care. *Journal of Consulting and Clinical Psychology*, *73*, 914–923. http://dx.doi.org/10.1037/0022-006X.73.5.914

Wampold, B. E., & Imel, Z. E. (2015). *The great psychotherapy debate: Research evidence for what works in psychotherapy* (2nd ed.). New York, NY: Routledge.