Chapter 8

Feedback Informed Treatment (FIT): Improving outcome with male clients one man at a time

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We now accept the fact that learning is a lifelong process of keeping abreast of change. And the most pressing concern is teaching people how to learn. (Peter Drucker)

Thankfully, research has confirmed the obvious: men and women are different. Available evidence shows, for example, that the two sexes differ in the amount, experience, and management of psychological stress *(Hall, Chipperfield, Perry, Ruthig, & Goetz, 2006, Roxburgh, 1996; Tytherleigh, Jacobs, Webb, Ricketts, & Cooper, 2007)*. The prevalence of depression and anxiety in women is twice that of men *(Clarkin & Levy, 2004; U.S. Department of Health and Human Services, Office on Women's Health, 2001)*, while men are far more likely to suffer from problems related to misuse of alcohol and drugs than women *(Kessler, McGonagle, Zhao, Nelson, Hughes, Eshelman, et al., 1994; Robbins, 1989; Robbins & Regier, 1991)*. Finally, research dating back over three decades documents that men and women differ in the rate, type, and amount of professional help sought, with men seeking and obtaining far *less* than women relative 'to the range and severity of problems that affect them' *(Addis & Mahalik, 2003, p. 6)*.

Based in part on such findings, sex and/or gender[7] have received increasing attention among helping professionals. In the last decade in particular, research, training materials, and practice guidelines have emerged, aimed at raising awareness of and fostering gender competence *(Addis & Mahalik, 2003; APA, 2007; Vasquez, 2007)*. Unfortunately, to date, few studies have examined whether such information and materials are effective beyond merely transferring knowledge to actually improving the outcome of care *(Hanssmann, Morrison, Russian, 2008; Owen, Wong, & Rodolfa, 2009; Sue, Zane, Levant, Silverstein, Brown, Olkin, & Taliaferro, 2006)*. Additionally, as Addis and Mahalik *(2003)* warn, an exclusive focus on the differences between the sexes is limited, 'in that it ... does not address the within-group and within-person variability, and *can be used to support stereotypes of men and women that constrain both genders*' *(p. 7)*.

How can clinicians avoid the twin pitfalls of ignorance and ideology? One possible solution is linking gender competence to individual clinician outcome *(Hubble & Miller, 2004; Miller, Duncan, & Hubble, 2005; Wampold, 2005)*. In contrast to what some believe, studies to date document that the outcome of psychotherapy does not vary based on the gender of the client *(see Clarkin & Levy 2004 for a review)*. Said another way, men and women are equally likely to benefit from treatment. At the same time, the same body of evidence clearly shows that not all psychotherapists are equally effective with men and women. In what is the only quantitative study on the subject in the

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7 Although used interchangeably here, in the professional literature, sex is typically used to refer to biological differences while the term gender is more broadly defined as the historical, cultural, psychological, and social experience of and meaning attributed to being male and female.

literature, Owen, Wong, & Rodolfa *(2009)* found that 'some psychotherapists did better with male clients, some did better with female clients, and the rest ... did equally well or equally poor with male and female clients' *(p. 454)*.

Measuring outcomes is not only useful for determining gender competence but has also been shown to improve the success rates of individual clinicians *(Miller, 2010; Hubble, Duncan, Miller, & Wampold, 2009)*. Indeed, multiple, independent randomized clinical trials (RCTs) show that formally assessing and discussing the client's experience of the process and outcome of care as much as doubles the rate of reliable and clinically significant change experienced by clients, decreases drop-out rates by as much as 50%, and cuts deterioration by one-third *(Miller, 2010)*. Such impressive results were, in part, responsible for the definition of 'evidence-based practice' adopted by the American Psychological Association (2006) that includes a recommendation of, 'monitoring of patient (sic) progress ...and alter[ing] or address[ing] problematic aspects of the treatment (e.g., problems in the therapeutic relationship or in the implementation of the goals of the treatment).' *(p. 276-77)*

In the sections that follow, we detail how clinicians can use feedback to inform treatment (FIT) thereby improving the outcome of services they offer to males and females delivered one man and one woman at a time.

What kind of feedback matters?

> *The proof of the pudding is in the eating. (Cervantes, Don Quixote)*

In 2006, Miller, Duncan, Brown, Sorrell, & Chalk published the results of a large study investigating the impact of providing regular, formal, ongoing feedback to clinicians regarding their clients' experience of the quality of the therapeutic relationship and progress in care. The choice of 'what' to measure and provide feedback about was simple. Next to pre-existing client characteristics, and regardless of treatment approach, ***the single largest contributor to success in treatment is the relationship between client and therapist** (Norcross, 2009)*. Indeed, evidence regarding the power of the therapeutic relationship is reflected in over 1,100 process-outcome findings *(Duncan, Miller, Wampold, & Hubble 2009)*, making it the most evidence-based concept in the treatment literature. At the same time, studies have shown that *changes in an individual's level of distress, functioning in close interpersonal relationships, and performance at work, school, or settings outside the home are strong predictors of successful therapeutic work (Miller, Duncan, & Hubble, 2004)*.

Choosing a measure to use can be challenging. In their book, *ssessing outcome in clinical practice*, Ogles, Lambert, & Masters *(1996)* note that over 1400 measures are currently in use for measuring the effectiveness of psychotherapy. That said, the particular scales employed by Miller et al. *(2006)* to assess the relationship and progress were the Session Rating Scale (SRS) *(Miller, Duncan, & Johnson, 2000)*, and the Outcome Rating Scale (ORS), *(Miller, & Duncan, 2000, appendix 1)*, respectively.

Briefly, both scales are short, 4-item, self-report instruments that have been tested in numerous studies and shown to have solid reliability and validity *(Miller, 2010)*. Most importantly perhaps, the brevity of the two measures insures they are also *feasible* for use in everyday clinical practice. After having experimented with other tools, the developers, along with others (i.e., Brown, Dreis, & Nace, 1999), found that 'any measure or combination of measures that [take] more than five minutes to complete, score, and interpret [are] not considered feasible by the majority of clinicians' *(Duncan & Miller, 2000, p. 96)*. Indeed, available evidence indicates that routine use of the ORS and SRS is high compared to other, longer measures (99% versus 25% at 1 year) *(Miller, Duncan, Brown, Sparks, & Claud, 2003)*.

Administering and scoring the measures is simple and straightforward. The ORS is administered at the beginning of the session. The scale asks consumers of therapeutic services to think back over the prior week (or since the last visit) and place a hash mark (or 'x') on four different lines, each representing a different area of functioning (e.g., individual, interpersonal, social, and overall well being). The SRS, in contrast, is completed at the

end of each visit. Here again, the consumer places a hash mark on four different lines, each corresponding to a different and important quality of the therapeutic alliance (e.g., relationship, goals and tasks, approach and method, and overall). On both measures, the lines are (or should be) ten centimetres in length (10 cm). As indicated in the *ORS and SRS Administration and Scoring Manual*:

> To score, determine the distance in centimetres to the nearest millimetre between the left pole and the client's hash mark on each individual item.
>
> Add all four numbers together to obtain the total score of the particular measure *(Miller & Duncan, 2001)*.

Two computer-based applications are available which can simplify the process of administering, scoring, and aggregating data from the ORS and SRS – especially in large and busy group practices and agencies. Detailed descriptions can be found online at: www.scottdmiller.com.

Returning to the study, Miller et al. *(2006)* trained 75 clinicians in the proper use of the tools and then began collecting data. For six months, outcomes and alliance scores were tracked but no feedback about progress in care or the quality of the relationship given. Once clinicians were exposed to the clients' experience of the relationship and outcome on a session by session basis, effectiveness rates soared – more than doubling in size by the end of the study (corrected effect size = .37 versus .79). Meanwhile, deterioration rates were cut in half (19% versus 8%). Moreover, such results were obtained without any attempt to formally control the type of treatment delivered and without the introduction of any new treatment modalities, programs, or diagnostic procedures.

Creating a 'culture of feedback'

> *Make your ego porous. Will is of little importance, complaining is nothing.... Openness, patience, receptivity ...is everything. (Rainer Maria Rilke)*

Novelty stores routinely sell a plaque poking fun at anyone who might want to offer feedback to another. 'We value your feedback and take all complaints seriously,' the sign states in large bold letters, and then continues 'please write it in the box below.' The size of the box – usually no bigger than 3mm in height and length – communicates *instantly* the true value of the feedback being sought. And while intended as a joke, the 'take-home' message could not be clearer: people can tell when someone is truly interested in their feedback.

Clearly, soliciting feedback from consumers of therapeutic services is more than administering the ORS and SRS. Clinicians must work at creating an atmosphere where clients feel free to rate their experience of the process and outcome of services: (1) without fear of retribution; and (2) with a hope of having an impact on the nature and quality of services delivered. Interestingly, empirical evidence from both business and healthcare demonstrates that consumers who are happy with the way *failures* in service delivery are handled are generally *more* satisfied at the end of the process than those who experience no problems along the way *(Fleming & Asplund, 2007)*. In one study of the ORS and SRS involving several thousand 'at risk' adolescents, for example, effectiveness rates at termination were 50 percent higher in treatments where alliances 'improved' rather than were rated consistently 'good' over time. The most effective clinicians, it turns out, consistently achieve *lower* scores on standardized alliance measures at the outset of therapy, thereby providing an opportunity to discuss and address problems in the working relationship – a finding that has now been confirmed in numerous independent samples of real-world clinical samples *(Miller, Hubble, & Duncan, 2007)*.

Beyond displaying an attitude of openness and receptivity, creating a 'culture of feedback' involves spending time to thoughtfully and thoroughly introduce the measures. Providing a rationale for using the tools is critical, as is including a description of how the feedback will be utilized to guide service delivery. Consequently, for the ORS, the introduction emphasizes the well-established finding that early change in treatment is a good

predictor of eventual outcome *(Duncan, Miller, Wampold, & Hubble, 2009)*. As modelled in the *Outcome and Session Rating Scales: Administration and Scoring Manual (Miller & Duncan, 2000)*, the clinician begins:

> '(I/We) work a little differently at this (agency/practice). (My/Our) first priority is making sure that you get the results you want. For this reason, it is very important that you are involved in monitoring our progress throughout therapy. (I/We) like to do this formally by using a short paper and pencil measure called the Outcome Rating Scale. It takes about a minute. Basically, you fill it out at the beginning of each session and then we talk about the results. A fair amount of research shows that if we are going to be successful in our work together, we should see signs of improvement earlier rather than later. If what we're doing works, then we'll continue. If not, however, then I'll try to change or modify the treatment. If things still don't improve, then I'll work with you to find someone or someplace else for you to get the help you want. Does this make sense to you?' *(p. 16)*.

At the end of each session, the therapist administers the SRS, emphasizing the importance of the relationship in successful treatment *and* encouraging negative feedback. For example:

> 'I'd like to ask you to fill out one additional form. This is called the *Session Rating Scale*. Basically, this is a tool that you and I will use at each session to adjust and improve the way we work together. A great deal of research shows that your experience of our work together – did you feel understood, did we focus on what was important to you, did the approach we took make sense and feel right – is a good predictor of whether we'll be successful. I want to emphasize that I'm not aiming for a perfect score – a 10 out of 10. Life isn't perfect and neither am I. What I'm aiming for is your feedback about even the smallest things – even if it seems unimportant – so we can adjust our work and make sure we don't steer off course. Whatever it might be, I promise I won't take it personally. I'm always learning, and am curious about what I can learn from getting this feedback from you that will in time help me improve my skills. Does this make sense?'

Making sense of measure-generated client feedback

> *'Signal-to-noise ratio'...refer[s] to the ratio of useful information to...irrelevant data (Wikipedia)*

In 2009, Anker, Duncan, & Sparks published the results of the largest randomized clinical trial in the history of couple therapy research. The design of the study was simple. Using the ORS and SRS, the outcomes and alliance ratings of two hundred couples in therapy were gathered at each treatment session. In half of the cases, clinicians received feedback about couples' experience of the therapeutic relationship and progress in treatment; in the other half, none. At the conclusion of the study, couples whose therapist had received feedback experienced twice the rate of reliable and clinically significant change as those in the non-feedback condition. Even more astonishing, at follow-up, couples treated by therapists not receiving feedback had nearly twice the rate of separation and divorce!

What constituted 'feedback' in the study? As in most studies to date *(c.f., Miller, 2010)*, the feedback was very basic in nature. Indeed, when surveyed, *none* of the clinicians in the study believed it would make a difference as *all* stated they already sought feedback from clients on a regular basis. That said, two kinds of information were made available to clinicians: (1) individual client's scores on the ORS and SRS compared to the clinical cut off for each measure; and (2) clients' scores on the ORS from session-to-session compared to a computer-generated 'expected treatment response' (ETR)

Beginning with the clinical cut-off on the SRS, scores that fall at or below 36 are considered 'cause for concern' and should be discussed with clients *prior* to ending the session as large normative studies to date indicate that fewer than 25% of people score lower at any given point during treatment *(Miller*

& Duncan, 2000). Single point decreases in SRS scores from session to session have also been found to be associated with poorer outcomes at termination – even when the total score consistently falls above 36 – and should therefore be discussed with clients *(Miller, Duncan, & Hubble, 2007)*. In sum, the SRS helps clinicians identify problems in the alliance (i.e., misunderstandings, disagreement about goals and methods) early in care thereby preventing client drop out or deterioration.

Consider the following example from a recent, first session of couples therapy where using the SRS helped prevent one member of the dyad from dropping out of treatment. At the conclusion of the visit, the man and woman both completed the measure. The scores of two diverged significantly, however, with the husband's falling below the clinical cut-off. When the therapist inquired, the man replied, 'I know my wife has certain ideas about sex, including that I just want sex on a regular basis to serve my physical needs. But the way we discussed this today leaves me feeling like some kind of 'monster' driven by primitive needs.' When the therapist asked how the session would have been different had the man felt understood, he indicated that both his wife and the therapist would know that the sex had nothing to do with satisfying primitive urges but rather was a place for him to feel a close, deep connection with his wife as well as a time he felt truly loved by her. The woman expressed surprise and happiness at her partner's comments. All agreed to continue the discussion at the next visit. As the man stood to leave, he said, 'I actually don't think I would have agreed to come back again had we not talked about this – I would have left here feeling that neither of you understood how I felt. Now, I'm looking forward to next time.'

Whatever the circumstance, openness and transparency are central to successfully eliciting meaningful feedback on the SRS. When the total score falls below 36, for example, the therapist can encourage discussion by saying:

> 'Thanks for the time and care you took in filling out the SRS. Your experience here is important to me. Filling out the SRS gives me a chance to check in one last time, before we end today, to make sure we are on the same page –

> that this is working for you. Most of the time, about 75% actually, people score 37 or higher. And today, your score falls at (a number 36 or lower), which can mean we need to consider making some changes in the way we are working together. What thoughts do you have about this?'

When scores have decreased a single point compared to the prior visit, the clinician can begin exploring the possible reasons by stating:

> 'Thanks so much for the time and care you took in filling out the SRS. As I've told you before, this form is about how the session went; and last week (using the graph to display the results), your marks totalled (X). This week, as you can see, the total is (X minus 1). As small as that may seem, research has actually shown that a decrease of a single point can be important. Any ideas about how today was different from prior visits and what if anything we need to change?'

Finally, when a particular item on the SRS is rated lower compared to the others the therapist can inquire directly about that item regardless of whether the total score falls below the cutoff:

> 'Thanks for the time and care you took in filling out the SRS. Your experience here is important to me. Filling out the SRS gives me a chance to check in one last time, before we end today, to make sure we are on the same page – that this is working for you. In looking over the scale, I've noticed here (showing the completed form to the client), that your mark on the question about 'approach and method' is lower compared to the others. 'What can you tell me about that?'

When seeking feedback via the SRS, it is important to frame questions in as 'task specific' a manner as possible. Research shows, for example, that people are more likely to provide feedback when it is not perceived as a criticism of the *person* of the other but rather about specific behaviors *(Coyle, 2009; Ericsson, Charness, Feltovich, & Hoffman, 2006)*. For example, instead

of inquiring generally about how the session went, or how the client felt about the visit, the therapist should frame questions in a way that elicits concrete, specific suggestions for altering the type, course, and delivery of services:

- 'Did we talk about the right topics today?'
- 'What was the least helpful thing that happened today?'
- 'Did my questions make sense to you?'
- 'Did I fail to ask you about something you consider important or wanted to talk about but didn't?'
- 'Was the session too (short/long/just right) for you?'
- 'Did my response to your story make you feel like I understood what you were telling me, or do you need me to respond differently?'
- 'Is there anything that happened (or did not happen) today that would cause you not to return next time?'

On the ORS, the clinical cut off is 25 and represents the dividing line between functional (above) and scores considered dysfunctional (below) *(Miller, Duncan, Brown, Sparks, & Claud, 2003)*. Said another way, clients who score below 25 are likely to benefit from treatment, while those falling above 25 at intake are *less* likely to show improvement and are, in fact, at higher risk of deterioration. With regard to the latter, available evidence indicates that 25-33% of people presenting for treatment score *above* the clinical cut-off at intake *(Miller, & Duncan, 2000; Miller, Duncan, Sorrell, & Brown, 2005)*.

The most common reason given by clients for scoring above the clinical cut-off at the first visit is that some one else sent them to or believes they need treatment (e.g., justice system, employer, family member, partner, etc.). In such instances, the client can be asked to complete the ORS *as if* they were the person who sent them. Time in the session can then be usefully spent on working to improve the scores of the 'concerned other.' A recent session with a man referred for 'counseling' by his physician illustrates how this process can work to build an alliance with people who are mandated into care.

Briefly, the man's score on the ORS at the initial session was 28, placing him above the cut-off and in the 'non-clinical' or 'functional' range of scores. The therapist plotted the scores on a graph saying, 'As you can see, your score falls above this dotted line, called the clinical cut-off. People who score above that line are scoring more like people who are not in treatment and saying life is generally pretty good.' The man nodded his head in agreement. 'That's right,' he then added.

'That's great,' the therapist said without hesitation, 'Can you help me understand why you have come to see me today then?'

'Well,' the man said, 'I'm OK, but *my family* – and my wife in particular – have been complaining a lot, about, well, saying that I drink too much.'

'OK, I get it,' the therapist responded, '*they* see things differently than you.' Again, the man nodded in agreement.

'Would you mind filling this in one more time?' she asked, 'as if you were your wife and family?' And when the items on the ORS were added up, the total had dropped to 15 – well below the clinical cut-off. Using a different colored pen, the therapist plotted the 'collateral score' on the graph. Pointing to the man's score, the therapist said, 'You're up here, at 28,' and then continued, 'but your family, they have a different point of view.'

'Exactly,' he said.

'What do you suppose it would take for your wife and family scores to go up?' the therapist asked. The first words out of his mouth were, 'I'd definitely have to cut down the drinking ...,' followed by a lengthy and engaged conversation regarding the family's concern about driving while intoxicated and the man's frequent inability to recall events after a night of heavy alcohol consumption.

Another common reason for scores falling above the clinical cut off at intake is that the client wants help with a very specific problem – one that does not impact the overall quality of life or functioning but is troubling nonetheless. Given the heightened

risk of deterioration for people entering treatment above the clinical cut-off, clinicians are advised against 'exploratory' and 'depth-oriented' work. The best approach, in such instances, is a cautious one, using the least invasive and intensive methods needed to resolve the problem at hand.

Finally, less frequent, although certainly not unheard-of, causes for high initial ORS include: (1) high functioning people who want therapy for growth, self-actualization, and optimizing performance; and (2) people who may have difficulties reading and writing or who have not understood the meaning or purpose of the measure. In the latter instance, time can be taken to explain the measure and build a 'culture of feedback' or, in the case of reading or language difficulties, the oral version *(available at: scottdmiller.com)* can be administered. For high functioning people caution is warranted. A strength-based, coaching-type approach focused on achieving specific, targeted, and measurable goals is likely to be most helpful while simultaneously minimizing risks of iatrogenic deterioration.

In addition to the clinical cut-off, clinicians in the couples study, as indicated above, received feedback comparing a client's score on the ORS to a computer generated 'expected treatment response' (ETR). As researchers Wampold and Brown *(2006)* have observed, 'Therapists are not cognizant of the trajectory of change of patients (sic) seen by therapists in general...that is to say, they have no way of comparing their treatment outcomes with those obtained by other therapists' *(p. 9)*. Using a large and diverse normative sample that included 300,000 plus administrations of the ORS, Miller et al. *(2004)* produced algorithms capable of plotting an average trajectory of change over time based on a person's initial score (e.g., level of functioning) on the measure. The resulting graphs resemble and serve a similar function as growth curves used in medicine to assess height, weight, and head circumference.

Available evidence indicates that clinicians are, on average, successful with 60-70% of the people they treat *(Duncan et al. 2009)*. Said another way, 30-40% of people in treatment make little or no progress or deteriorate in care. Having access to

individual client trajectories enables clinicians to identify those at risk for a null or negative outcome at a time when altering, augmenting or even referring to other services (or providers) can improve the chances of success. In the study, Anker et al. *(2009)* provided therapists with a table that could be used to determine the ETR for each client. Clinicians can access the essentially same information in either of the two computer-based applications mentioned previously.

Improving the outcome of psychotherapy one man at a time

> *One man may hit the mark, another blunder; but heed not these distinctions. Only from the alliance of the one, working with and through the other, are great things born. (Antoine de Saint-Exupery)*

Awareness regarding the nature, role, and impact of gender differences in the practice of psychotherapy has grown steadily over the last decade. Despite the development of training materials and practice guidelines aimed at fostering gender competence, few studies have examined whether such information and materials are effective beyond merely transferring knowledge to actually improving the outcome of care. The evidence that does exist clearly documents significant variability between clinicians, with some being consistently more or less effective with one gender or the other.

The solution proposed by FIT is linking gender competence to individual clinician outcome. As the data reviewed in this chapter document, the integration of routine ongoing feedback, regarding the client's perception of the therapeutic relationship and progress in treatment, not only decreases differences in outcome between clinicians but simultaneously leads to significant improvements in the retention and success rates of individual clients. In short, FIT improves the effectiveness of psychotherapy one client – man or woman – at a time.