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12
Feedback-Informed Treatment (FIT)
Improving the Outcome of Sex Therapy One Person at a Time

SCOTT D. MILLER, Ph.D. AND KAREN M. DONAHEY, Ph.D.

It's what you learn after you know it all that counts.

John Wooden

A great debate rages in the field of psychological treatments (Wampold, 2001). On one side are those who hold that behavioral health interventions are similar to medical treatments (Barlow, 2004). The therapies work, they believe, because like penicillin they contain specific ingredients remedial to the disorder being treated. As such, advocates of this perspective emphasize diagnosis, treatment plans, and adherence to so-called "validated" treatments (Chambless & Ollendick, 2001; Huppert, Fabbro, & Barlow, 2006; Siev, Huppert, & Chambless, 2009). On the other side of the debate are those who argue that psychotherapy, while demonstrably effective, is incompatible with the medical view (Duncan, Miller, Wampold, & Hubble, 2009; Hubble, Duncan, & Miller, 1999; Wampold, 2001). Proponents of what has been termed the "contextual" perspective highlight the lack of evidence for differential effectiveness among the 250 competing psychological treatments, suggesting instead that the efficacy of psychotherapy is more parsimoniously accounted for by a handful of curative factors shared by all (Lambert, 1992; Miller, Duncan, & Hubble, 1997).

Not surprisingly, the field of sex therapy has mirrored the larger debate between the "medical" and "contextual" perspectives. Over the last two decades, the conceptualization of sexuality and sexual disorders has grown in complexity, and the number and type of available treatments has increased. During that same period, the treatment of sexual dysfunction has become increasingly medicalized (Plaut, 1998). Whether psychological, pharmacological, or surgical in nature, sex therapy is, as Althof (2010) summarized in a recent issue of the *Journal of Sexual Medicine*, "a specialized...array of

technical interventions [italics added] known to effectively treat...sexual dysfunction" (p. 6). According to this perspective, progress is made by "testing the effectiveness of...*the critical components* [italics added] of treatment" (Weeks, Gambescia, & Hertlin, 2009, p. 402).

On the other side of the debate, Donahey and Miller (2001) argue that "successful 'sex therapy' is more about therapy with people who happen to be experiencing sexual difficulties than about the application of a unique therapeutic modality or treatment technique (e.g., squeeze technique, sensate focus)" (p. 212). The authors, citing a paucity of controlled outcome and process research supporting the medical view (e.g., diagnosis + treatment = cure), suggest working purposefully to heighten the contribution of factors associated with all effective approaches, including the incorporation of available client resources and chance change-producing events, accommodation of motivational readiness, tailoring of the therapeutic relationship, creation of hope and expectancy, and the provision of a healing rationale and ritual (Hubble, Duncan, & Miller, 1999; Wampold, 2001).

Despite the lack of definitive findings supporting one view or the other, the fact remains, as Schover and Leiblum (1994) note, that sex therapy is "one of the more effective psychotherapies, when practiced *appropriately* [italics added]" (p. 24). Many of late have suggested that integration of the medical and contextual perspectives (e.g., specific *and* common factors) represents the best option for defining "appropriate" practice (Althof, 2010; Bancroft, 2009; Rosen, 2007). At first glance, such a proposal has a certain common-sense appeal. It is, after all, congruent with the pragmatic and eclectic orientation adopted by most psychotherapists (Cook, Biyanova, Elhai, Schnurr, & Coyne, 2010; Prochaska, Nash, & Norcross, 1986; Watkins, Lopez, Campbell, & Himmell, 1986). Second, and related, integrating the medical and contextual views presumably adds therapeutic options. Ultimately, however, the call for integration invites the question: Given the sharply contrasting points of view and dizzying array of treatments available, how can the practitioner know what to do, when to do it, and with whom?

Making Treatment Decisions Under Uncertainty

> However beautiful the strategy, you should occasionally look at the results.
>
> **Winston Churchill**

Recent developments in the field of psychotherapy (Hubble, Duncan, Miller, & Wampold, 2009) are on track to providing an empirically robust and clinically feasible answer to the question of "what works for whom?" Based on the pioneering work of Howard, Moras, Brill, and Martinovich (1996) and others (c.f., Brown, Dries, & Nace, 1999; Lambert, 2009; Miller, Duncan, & Hubble, 2003), this approach to evaluating psychological treatments transcends the "medical versus contextual" debate by focusing on routine, ongoing monitoring of engagement in and progress of therapy (Lambert, 2001). Such data, in turn, are utilized to inform decisions about the kind of treatment offered as well as whether to continue, modify, or even end services.

Multiple, independent randomized clinical trials (RCTs) show that formally assessing and discussing clients' experience of the process and outcome of care doubles the rate of reliable and clinically significant change, decreases drop-out rates by as much as 50%, and cuts deterioration rates by one-third (Miller, 2010). As just one example, consider a study by Anker, Duncan, and Sparks (2009) involving more than 200 heterosexual couples treated in a real-world clinical setting by 10 clinicians. Importantly, no efforts were made to control the type or amount of services offered. Instead, therapists either received ongoing feedback regarding client engagement and progress or did not. At the conclusion of the study, couples whose therapist had received ongoing feedback were four times more likely to experience both reliable and clinically significant change. Not only were the measured improvements maintained at follow up, but couples in the feedback condition were 50% less likely to be separated or divorced.

Briefly, "feedback-informed treatment" (FIT) is based on several well-established findings. The first is: Psychotherapy works. Studies dating back over 30 years document that the average treated person is better off than 80% of the untreated sample in most studies (Hubble et al., 2009; Wampold, 2001). Second, the general trajectory of change in successful treatment is predictable, with the majority of progress occurring earlier rather than later (Brown et al., 1999; Hansen, Lambert, & Forman, 2002). Third, despite the proven efficacy of psychotherapy, there is considerable variation in both the engagement in and outcome of individual episodes of care. With regard to the former, for example, available evidence indicates that nearly 50% of those who initiate treatment drop out before achieving a reliable improvement in functioning (Bohanske & Franczak, 2009; Garcia & Weisz, 2003; Wierzbicki & Pekarik, 1993). Fourth, significant differences in outcome exist between practitioners. Indeed, a large body of evidence shows that "*who*" provides a treatment contributes eight to nine times more to outcome than "what" particular treatment was offered (Wampold, 2005). Such findings indicate that people seeking treatment would do well to choose their provider carefully, as it is the therapist—*not* the treatment approach—that matters most in terms of results. Fifth, and finally, a hefty portion of the variability in outcome among clinicians is attributable to the therapeutic alliance. For example, in a study involving 80 clinicians and 331 clients, Baldwin, Wampold, and Imel (2007) reported that differences in the alliance accounted for a staggering 97% of the variability in outcomes among therapists. By contrast, client variability in the alliance was found to be "unrelated to outcome" (p. 842).

With so many factors at play influencing outcome at the time of service delivery, it is simply impossible to know with absolute certainty what treatment or treatments delivered by a particular therapist will reliably work with a specific client. Of course, clinicians must have ideas, a plan, and methods—whether informed by medical, contextual, or integrative perspectives. In the end, however, only real-time monitoring and utilization of outcome and alliance data can maximize the fit between client, therapist, and treatment.

Although no studies on FIT specific to sex therapy have been published to date, sexual difficulties were assessed as part of an overall measure of "marital adjustment" included as a dependent variable in the study by Anker et al. (2009). Additionally, Branney and Barkham (2006) reported positive results in a feasibility study involving the routine use of an outcome measure in sex therapy. Finally, the evidence regarding sex therapy that does exist echoes many of the findings noted previously from the field of psychotherapy in general. For example, in an article published in the *Journal of Sex and Marital Therapy*, Estrada and Holmes (1999) found that couples consistently identified the therapeutic alliance as an "important ingredient of therapy" (p. 151). Indeed, available evidence documents a strong, positive correlation between retention, outcome, and the therapeutic alliance in work with couples (Anker et al., 2009). Other research shows that sex therapy works but, as is true of psychotherapy in general, dropout rates are a problem and effectiveness varies significantly by practitioner (Gregoire & Bhugra, 1996). Therefore, regardless of problem type or specialty, "There is no excuse," as researchers Lambert et al. (2003) conclude in a review of studies on FIT, "for failing to assist clients by using these methods.... *It is time to routinely track client outcome* [italics added]" (p. 260, emphasis added).

Becoming FIT in Clinical Practice

> It is not the strongest of the species that survives, nor the most intelligent, but the one most responsive to change.
>
> **Charles Darwin**

Incorporating FIT into therapies with people with sexual difficulties need not be complicated, time-consuming, or expensive. Clinicians can simply choose from among the many paper and pencil rating scales available. Several good sources exist that front-line practitioners can consult for information about existing instruments (c.f., Fischer & Corcoran, 2007; National Institute for Mental Health in England, 2008; Ogles, Lambert, & Fields, 2002).

Two measures that have proven not only to be valid and reliable but also clinically feasible are the *Outcome Rating Scale* and *Session Rating Scale* (ORS & SRS; see appendix at end of chapter) (Miller & Duncan, 2000a, 2000b; Miller, Duncan, & Johnson, 2000). The first, the ORS, is a four-item measure

administered at the outset of each session that assesses the impact of services on client functioning in four domains documented to be reasonable indicators as well as strong predictors of successful therapeutic work (Miller, Duncan, & Hubble, 2002). The second, the SRS, is a four-item measure of the therapeutic alliance administered and discussed at the conclusion of each visit.

Given the brevity of the scales, administration and interpretation take only minutes. Most importantly, the measures have been employed in several studies—including the study by Anker and colleagues (2009) noted previously—and shown to decrease dropout rates and improve outcome across a diverse clinical population (Miller, Duncan, Sorrell, Brown, & Chalk, 2006; Reese, Nosworthy, & Rowlands, 2009; Reese et al., 2009; Sorrell, 2007).

Clearly, soliciting and using feedback to guide service delivery involves more than administering one or more measures when meeting with clients. According to Miller and Bargmann (2010), the effect of FIT is enhanced when clinicians purposefully work at: (1) creating a culture of feedback; (2) integrating measure-generated feedback into care on a regular basis; and (3) learning to fail successfully. In the material that follows, each of these steps is discussed and illustrated using a variety of examples from clinical work with people presenting with sexual difficulties.

Creating a Culture of Feedback

Interestingly, empirical evidence from both business and health care demonstrates that people who are happy with the way *failures* in service delivery are handled are not only more satisfied at the end of the process than those who experience no problems, but crucially, are *more* engaged going forward (Fleming & Asplund, 2007). Research specific to psychotherapy confirms and extends these findings. For example, in one study of the ORS and SRS involving several thousand clients, outcomes at termination were 50% higher in treatments where alliances "improved" rather than being rated consistently "good" over time (Miller, Hubble, & Duncan, 2007). 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 (Anker, Owen, Duncan, & Sparks, 2010).

Soliciting feedback means working purposefully to create 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. Sharing negative feedback obviously requires the presence of a strong and safe alliance which, as the research cited earlier by Baldwin and colleagues (2007) makes clear, is the responsibility of the therapist.

Providing a rationale for using the tools, as well as a description of how the feedback will be utilized to guide service delivery, is a helpful first step. For example, when assessing the alliance at the end of a visit via the SRS, the

therapist would do well to emphasize the importance of the relationship in successful treatment *and* encourage 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?

The same care taken when introducing a measure of the therapeutic alliance (i.e., SRS) should be employed when explaining the purpose of monitoring the effects of treatment—in particular, highlighting the prognostic value of early change. For example, when using the ORS to track client progress:

> I'd like to ask you to complete a brief paper and pencil measure. It takes about a minute. I'll ask that you fill it out at the beginning of each session and then we'll talk about the results together. Think of it as the psychological equivalent of a blood pressure cuff or blood test. A fair amount of research shows that if what I know how to do is going to help, there should be measurable signs of improvement earlier rather than later. If what we do 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?

Integrating Measure-Generated Feedback Into Care

A routine part of most health care interventions is comparing a measure to a known baseline or benchmark (Hannan et al., 2005). Until very recently, behavioral health professionals had no way of comparing progress made by individual clients with outcomes obtained by other therapists. The result, as researchers Wampold and Brown (2006) point out, is "therapists are *not* particularly adept at identifying treatment success and failure" (p. 8). In one representative study involving a large sample of clients and therapists, for example, clinicians consistently over-predicted improvement and failed to

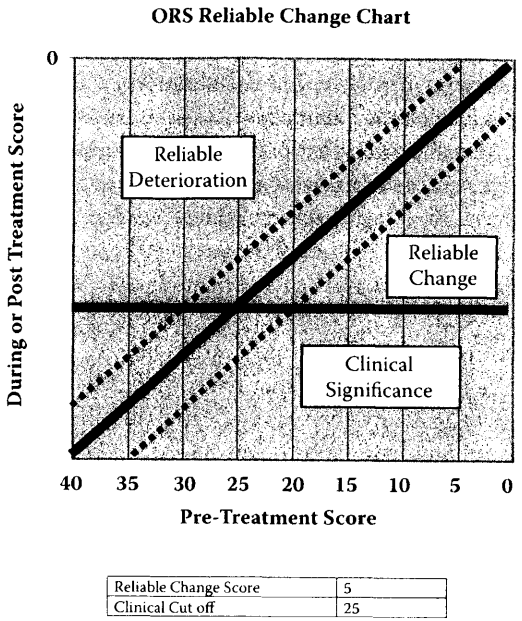


Figure 12.1 ORS reliable change chart.

detect deterioration despite having been informed of the base rates at the outset (Hannan et al., 2005).

A large part of the improvement in retention and outcome achieved by FIT occurs because clinicians are able to compare individual client response in real time with session-by-session normative data and make adjustments prior to clients dropping out, stagnating, or deteriorating in care (Lambert, 2009). One easy method used in a number of studies to assess an individual's rate of progress is the "reliable change index" (RCI). Briefly, the RCI is a statistical benchmark for determining whether a measured improvement is due to therapy or merely the result of chance variation in the instrument. On the ORS, for example, the RCI is 5 points (Miller & Duncan, 2000b). Simply put, clients can be considered significantly improved when a change in ORS scores from session to session is greater than 5 (Christensen & Mendoza, 1986; Jacobsen, Follette, & Revenstorf, 1984).

Clinicians can quickly determine whether variation in ORS scores meets or exceeds the reliable change index by using the chart in Figure 12.1. Briefly, a client's first session ORS score is plotted along the horizontal axis, while the current or last ORS score is tracked along the vertical axis. As indicated on the graph, change is considered both reliable *and* clinically significant when it is greater than 5 points and passes the clinical cutoff—a statistical index that will be discussed shortly.

Given that the majority of change in therapy occurs earlier rather than later, significant progress toward the RCI should, on average, occur during the first handful of sessions. The absence of movement or any deterioration should be discussed openly with the client at each visit. In such circumstances, it can be useful to explore changing the focus, type, and amount of services being offered. The process is facilitated by plotting and discussing scores from session to session on a graph together with clients (see Figures A.1 and A.2 in the appendix to this chapter).

Another benchmark that can be used to guide care is the clinical cutoff—a statistically derived index for determining whether a particular score on a measure falls within a normal or clinical range. Beginning with the SRS, large normative studies to date indicate that fewer than 25% of people score lower than a total score of 36 at any given point during treatment (Miller & Duncan, 2000b). As a result, any score at or below 36 should be considered "cause for concern" and discussed with the client *prior* to ending the session.

> Consider the following example from a recent first session of couples therapy where using the SRS helped prevent one member of the couple from dropping out of treatment (Miller & Bargmann, 2010). At the conclusion of the visit, the man and woman both completed the measure. The scores of the two diverged significantly, however, with the husband's falling below the clinical cutoff. 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."

When seeking feedback via the SRS, it is important to frame questions in as "task specific" a manner as possible. Research shows 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). Therefore, instead of making general inquiries about how the session went or how the client felt about the visit, the therapist should frame questions in ways that elicit concrete, specific suggestions for altering the type, course, and delivery of services.

Turning to the ORS, the clinical cutoff on the measure is 25 (Miller and Duncan, 2000b) and serves as the dividing line between a normal and clinical range of distress regarding functioning. Simply put, scores below 25 are more typical of people who are clinically distressed and seeking services, while those falling above are more common among people who are not in treatment or believe they do not need professional help.

> As the following dialogue demonstrates, therapists can use the cutoff to gauge the level and intensity of treatment to forestall deterioration and maintain optimal levels of engagement. The conversation took place between the therapist and male partner in a heterosexual relationship presenting with sexual difficulties. While his partner scored at a level indicative of moderate distress, the man scored significantly higher than the clinical cutoff.
>
> *Therapist:* [showing plotted score on graph] Your score, as you can see here, uh, is a 32...
> *M:* [nodding] Mmm huh.
> *Therapist:* ...which places you *above* this dotted line...
> *M:* Yes.
> *Therapist:* So for you things are fairly good.
> *M:* That's right. As I said, I'm mostly here for her, uh, because she's, you know...I don't really have a prob...I *want* to have sex. *She* has...she doesn't want to.
>
> In discussing the man's scores, a situation common to work with couples emerges. One member of the dyad attends the session to support the other, who is viewed as having the problem. Securing the former's ongoing, active engagement in problem solving can be challenging when ORS scores indicate a lack of distress. In such instances, systemically oriented questioning can be used "to explore and shift premises that constrain family members' relationships and ability to resolve conflictual or painful issues" (Brown, 1997, p. 111). In the following dialogue, for example, the therapist asks the man to imagine how his partner might rate him on the ORS:
>
> *Therapist:* I'm curious, if I were to ask your wife how she would fill in the form about you, how do you suppose it would look?
> *M:* [laughing] *Lower* for sure.
> *Therapist:* You're so certain.
> *M:* [turning to his partner] Isn't that true?
> *Therapist:* [interrupting and speaking first to the woman] Before you answer that, let me ask *you* [to the man], what might

Deborah say would be different if those "lower" scores began to go up—even a little.

M: [looking at his partner] She would say that I wouldn't be as stressed out from work...

Therapist: Uh huh.

M: *I* think I handle things pretty well...

Therapist: That's what your scores say...

M: ...but Deborah says, uh, that I'm irritable a fair bit of the time.

As the session continued, the therapist—mindful of the man's original high score on the ORS—continued to frame questions from the perspective of his partner. Emphasis was placed on developing a concrete picture of future, healthy functioning together rather than on situating blame for the problem or convincing one partner to agree with the other (Miller, Duncan, & Hubble, 1997). By the end of the visit, both members of the couple were engaged in the therapeutic process. Among other things, the man agreed to record his "level of stress" on a scale from 1 to 10 prior to returning home at the end of the workday. The woman would make the same rating. Both agreed to discuss their respective ratings and note differences in feelings of openness and intimacy from day to day. In the session that followed, the couple confirmed experiencing a greater degree of closeness on days that the man was perceived by both to be less stressed. The man, in particular, reported finding it personally helpful to "pause and reflect" prior to entering the house each evening.

In conclusion, the ORS can be used to triage clients according to need, identify those most at risk for deterioration and dropout, and determine whether adequate progress is occurring. In all instances, the key to successful integration of measure-generated feedback in care is engaging the client in an open and collaborative dialogue.

Learning to Fail Successfully

Available evidence indicates that clinicians are, on average, successful with 50%–70% of the people they treat (Duncan et al., 2009). Said another way, 30%–50% of people who access professional help make little or no progress or actually worsen in therapy. The previously reviewed research documents that integrating formal feedback into treatment significantly improves the probability of a successful outcome while simultaneously decreasing the risk of dropout and deterioration. As is true of many if not all of life's pursuits, perfect results remain elusive. Even when feedback-informed, a significant percentage of episodes of care—as high as 25%—will fail to produce a measurable improvement. The challenge for clinicians in such instances is to "fail successfully".

As noted previously, a lack of improvement or deterioration in therapy should be discussed openly and in a transparent manner with clients. Early on, such discussions typically center on changing the "what" of treatment; in particular, the focus, type, and amount of services being offered. Should a client worsen or still fail to improve, the clinician can then explore changing the "where" of treatment. For example, a referral can be made for further evaluation (e.g., medical, psychological, psychiatric), or additional therapeutic or support services can be added (e.g., therapy or support group, medical treatment, self-help, community resources). When modifying the "what" and "where" of treatment prove unsuccessful, clinicians must consider changing "who" is providing the service.

FIT clinicians accept that they can and will not—regardless of training, years of experience, reputation, or established success rate—help everyone they meet. Even under the most optimal conditions, no provider can be "all things to all people." Some relationships simply do not work. In such instances, a therapist *fails successfully* by securing client engagement in an organized continuum of possibilities (e.g., community resources, natural alliances with the family and significant others, and formal treatment and care with another clinician or health care institution) beyond the present services (Miller, Mee-Lee, Plum, & Hubble, 2005). Doing otherwise not only guarantees the continuation of unproductive work, but heightens the risk of client dropout and deterioration. Crucially, when care has been taken to build a "culture of feedback" that includes the possibility of treatment failure, clients are less inclined to blame themselves or the therapist and more likely to maintain the motivation necessary to continue problem-solving efforts.

Summary

Over the last three decades, the conceptualization of sexual dysfunction has grown in scope and complexity. Meanwhile, the number of therapies, both medical and psychological in nature, has increased. With a wide variety of treatments available and little evidence of differential effectiveness, it is difficult for practicing sex therapists to know with any assurance "what works with whom?" Although some have argued that "integration" represents the best option for defining "appropriate" practice, an alternative view is that real-time monitoring and utilization of outcome and alliance data can maximize the fit between client, therapist, and treatment. Three steps were presented for integrating measure-generated feedback into treatment of people presenting with sexual concerns.

Appendix 1

Outcome Rating Scale (ORS)

Name _____ Age (Yrs): _____ Sex: M / F

Session # _____ Date: _____

Who is filling out this form? Please check one: Self _____ Other _____

If other, what is your relationship to this person? _____

Looking back over the last week since your last visit, including today, help us understand how you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels. *If you are filling out this form for another person, please fill out according to how you think he or she is doing.*

Individually
(Personal well-being)

I----------I

Interpersonally
(Family, close relationships)

I----------I

Socially
(Work, school, friendships)

I----------I

Overall
(General sense of well-being)

I----------I

Figure A.1 Outcome Rating Scale (© 2000, Scott D. Miller and Barry L. Duncan).

Session Rating Scale (SRS V.3.0)

Name _____ Age (Yrs): _____

ID # _____ Sex: M / F

Session # _____ Date: _____

Please rate today's session by placing a mark on the line nearest to the description that best fits your experience.

Relationship

I did not feel heard, understood, and respected. I----------I I felt heard, understood, and respected.

Goals and Topics

We did *not* work on or talk about what I wanted to work on and talk about. I----------I We worked on and talked about what I wanted to work on and talk about.

Approach or Method

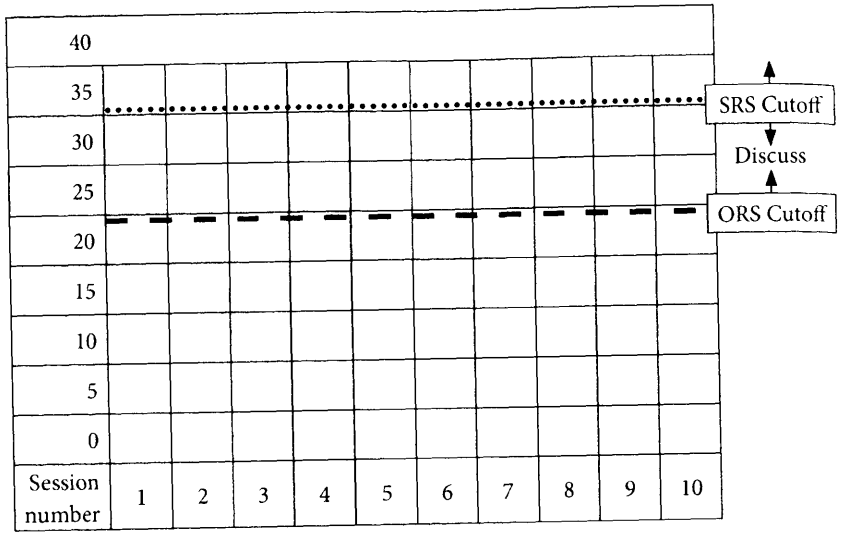
The therapist's approach is not a good fit for me. I----------I The therapist's approach is a good fit for me.

Overall

There was something missing in the session today. I----------I Overall, today's session was right for me.

Figure A.2 Session Rating Scale (© 2002, Scott D. Miller, Barry L. Duncan, & Lynn Johnson).

ORS & SRS Graph



Working copies of the measures can be obtained free of charge at:
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