Feedback Informed Treatment (FIT):

Improving the Outcome of Psychotherapy One Person at a Time

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Feedback Informed Treatment (FIT)

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"It is the big choices we make that set our direction. It is the smallest choices we make that get us to the destination."

Shad Helmstetter

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A "great debate" is raging in the field of psychotherapy (Wampold, 2001). On one side are those who hold that behavioral health interventions are similar to medical treatments (Barlow, 2004). Therapies work, they believe, because like penicillin they contain specific ingredients remedial to the disorder being treated. Consistent with this perspective, emphasis is placed on diagnosis, treatment plans, and adherence to so-called "validated" treatments (Siev, Huppert, & Chambless, 2009; Huppert, Fabbro, & Barlow, 2006; Chambless & Ollendick, 2001). The "medical model," as it is termed, is arguably the dominate view of how psychotherapy works. It is also the view held by most people who seek behavioral health treatment.

On the other side of the debate are those who argue that psychotherapy, while demonstrably effective, is incompatible with the medical view (Wampold, 2001; Duncan, Miller, Wampold, & Hubble, 2010; Hubble, Duncan, & Miller, 1999). 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). Of particular importance from this point of view are extratherapeutic factors and

the therapeutic relationship. As in the example above, emphasis is placed on the strengths, resources, and goals of the person seeking help.

The challenge for practitioners, given the sharply diverging points of view and dizzying array of treatments available, is knowing what to do, when to do it, and with whom? Thankfully, recent developments 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, Martinovich (1996) and others (c.f., Lambert, 2010; Brown, Dries, & Nace, 1999; Miller, Duncan, & Hubble, 2005; Duncan, Miller, Wampold, & Hubble, 2010), this approach transcends the "medical versus contextual" debate by focusing on routine, ongoing monitoring of engagement in and progress of therapy (Lambert, 2010). 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. Indeed, multiple, independent randomized clinical trials now show that formally and routinely assessing and discussing clients' experience of the process and outcome of care effectively 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).

In the sections that follow, detailed instructions and examples are given for using feedback to inform treatment. All clinicians, whether aligned primarily with the medical or contextual views of psychotherapy, can benefit, using the resulting information to improve the outcome of the services they offer one person at a time.

What Kind of Feedback Matters?

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"The proof of the pudding is in the eating."

Cervantes, *Don Quixote*

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Feedback-informed treatment or FIT is based on several well-established findings from the outcome literature. 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 (Duncan, Miller, Wampold, & Hubble, 2010; Smith & Glass, 1977; Wampold, 2001). Second, the general trajectory of change in successful treatment is predictable, with the majority of progress occurring earlier rather than later (Brown, Dreis, and Nace, 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, 2010; Kazdin, 1996; Garcia & Weisz, 2002; Wierzbicki & Pekarik, 1993). Fourth, significant differences in outcome exist between practitioners. Indeed, a large body of evidence shows that *"who"* provides a treatment contributes 8 to 9 times more to outcome than "what" particular treatment offered (Wampold, 2005; Miller, Hubble, & Duncan, 2007; Miller & Hubble, 2007). 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).

Taken together, the foregoing findings indicate that real-time monitoring and utilization of outcome and alliance data can maximize the "fit" between client, therapist, and treatment. Simply put, with so many factors at play influencing outcome at the time of service delivery, it is simply impossible to know a priori what treatment or treatments delivered by a particular therapist will reliably work with a specific client. Regardless of discipline or theoretical orientation, clinicians must determine if the services being offered are working and adjust accordingly.

Two simple scales that have proven useful for monitoring the status of the relationship and progress in care are the Session Rating Scale (SRS [Miller, Duncan, & Johnson, 2000]), and the Outcome Rating Scale (ORS, [Miller, & Duncan, 2000]). The SRS and ORS measure alliance and outcome, respectively. Both scales are short, 4-item, self-reports instrument 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" (p. 96, Duncan & Miller, 2000). 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, by 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 ten centimeters in length. Scoring is a simple matter of determining the distance in centimeters (to the nearest millimeter) between the left pole and the client's hash mark on each individual item and then adding the four numbers together to obtain the total score (the scales are available in numerous languages at www.scottdmiller.com/?q=node/6).

In addition to hand scoring, a growing number of computer-based applications are available which can simplify and expedite the process of administering, scoring, interpreting, and aggregating data from the ORS and SRS. Such programs are especially useful in large and busy group practices and agencies. Detailed descriptions of the other applications can be found online at www.scottdmiller.com.

Creating a "Culture of Feedback"

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"My priority is to encourage openness and a culture that is willing to acknowledge when things have gone wrong."

John F. Kennedy

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Of course, soliciting clinically meaningful feedback from consumers of therapeutic services requires more than administering two scales. 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 taking time to introduce the measures in a thoughtful and thorough manner. Providing a rationale for using the tools is critical, as is including a description of how the feedback will be used to guide service delivery (e.g., enabling the therapist to catch and repair alliance breaches, prevent dropout, correct deviations from optimal

treatment experiences, etc). Additionally, it is important that the client understands that the therapist is not going to be offended or become defensive in response to feedback given. Instead, therapists must take client's concerns regarding the treatment process seriously and avoid the temptation to interpret feedback clinically. When introducing the measures at the beginning of a therapy, the therapist might say:

> "(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?" (Miller & Duncan, 2004; Miller & Bargmann, 2011).

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

> "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 I'm taking 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?" (Miller & Bargmann, 2011).

Integrating Feedback into Care

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"If we don't change direction, we'll end up where we're going."

Professor Irwin Corey

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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 during each treatment session. In half of the cases, clinicians received feedback about the couples' experience of the therapeutic relationship and progress in treatment; in the other half, none. At the conclusion of the study, couples whose therapist 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).

Integrating the Clinical Cutoff into Care

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, 2004). 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, Hubble, & Duncan, 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 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. Looking at 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 being willing to give me this feedback. 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 totaled (X). This week, as you can see, the total is (X – 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 may need to change?"

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

"Thanks for taking this form so seriously. It really helps. I really want to make sure we are on the same page. Looking at the SRS gives me a chance to make sure I'm not missing something big or going in the wrong direction 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). In addition, 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 clinical (above) and scores considered non-clinical (below) (Miller, Duncan, Brown, Sparks, & Claud, 2003). Importantly, clients who score below 25 are likely to show measured 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 in care. With regard to the latter, available evidence indicates that between 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 someone 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 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. The therapist quickly responded with a request, "Would you mind filling this in one more time then, as if you were your wife and family?" 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," the man said, nodding his head and signaling agreement. When the therapist then asked what it would take for the score of his wife and family to go up, the first words out of the man's 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 can be administered. For high functioning people, 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 deterioration.

Integrating the Expected Treatment Response (ETR) into Care

In addition to the clinical cut-off, clinicians in the couple 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 (2005) 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 the largest normative sample to date, including 427,744 administrations of the ORS, 95,478 episodes of care delivered by 2,354 providers, Performance Metrics developed a set of algorithms capable of comparing individual consumer progress to both successful and unsuccessful treatment episodes. Adjustments can be made to the services offered when the client's session by session outcomes fit the ETR of treatments that ended unsuccessfully (see Figure 3).

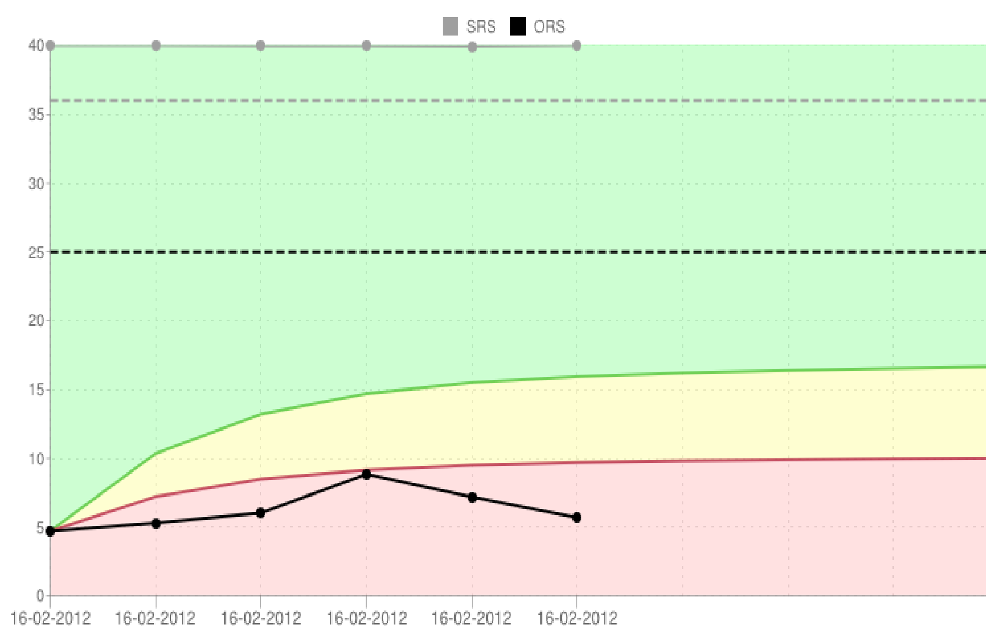

Figure 3: The green area represents successful outcomes; the red area represents unsuccessful outcomes. The solid black line represents the actual ORS score (Screen shot courtesy of fit-outcomes.com)

Available evidence indicates that clinicians are, on average, successful with 60-70% of the people they treat (Duncan, Miller, Wampold, & Hubble, 2010). 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 latest algorithms developed by Performance Metrics in the computer-based applications mentioned previously.

So how can clinicians integrate the information about ETR in their work with clients in everyday practice? Progress falling short of the ETR should prompt discussion focused on identifying barriers and developing a plan for altering or augmenting services in order to bring about the desired change.

Consider the following discussion between a clinician and client regarding the ETR. Briefly, the client is a 20 year old female being treated for depression. Two years prior to her first visit with the therapist, the client's mother died unexpectedly from a brain hemorrhage. At the initial session, the ORS was administered and the woman scored 15.4, well below the clinical cut off. The therapist's working hypothesis during the first 3 visits was that the depression was caused by grief over the death. As can be seen in Figure 4, the client felt positive about the sessions, with scores on the SRS going up over time. At the same time, however, ORS scores remained unchanged indicating a

lack of improvement. Using the ETR as a guide, the therapist initiated a conversation with the client at the fourth visit.

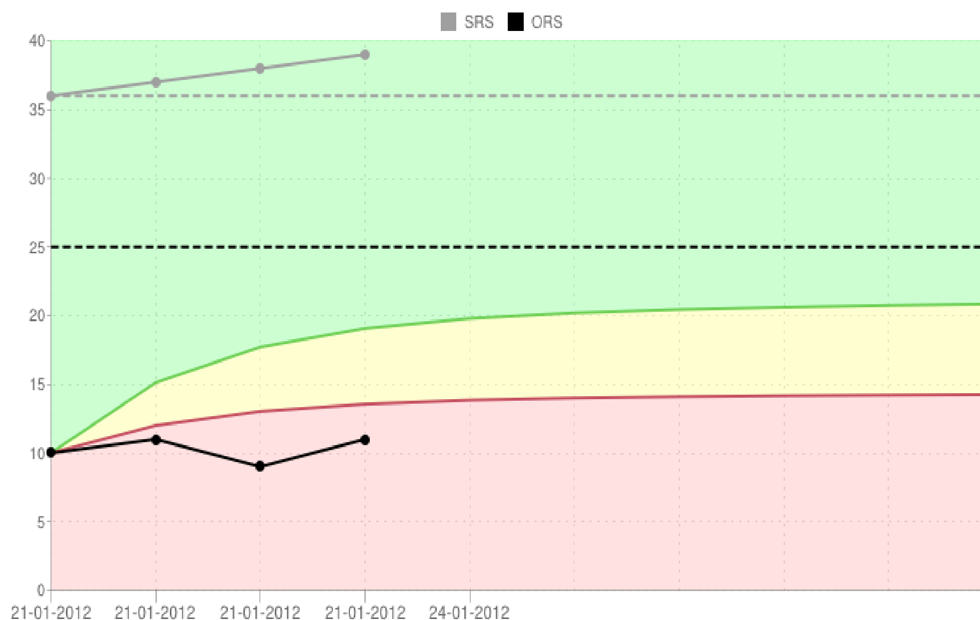

Figure 4: The dotted lines on the graph (on 25 and 36) represent the clinical cutoff for the ORS and the alliance cutoff for the SRS. The green area represents the expected treatment response (ETR) for a successful treatment episode. The solid black line is the actual ORS score for the client, and the solid gray line is the actual SRS score (Screen shot courtesy of fit-outcomes.com)

T: Looking at your graph, it seems that despite our efforts to work on relieving your sadness by talking about your mother, you are not feeling any better than when we started working together. Is that right?

C: Yeah. It won't go away, these feelings.

T: You can see that your scores fall below the red line, many people are feeling somewhat better by now, up around the green line. Any ideas about that?

C: Well, actually, yes.

T: I'm curious what your thoughts are?

C: I'm not sure this is about my mom.

T: You are thinking the problem lies elsewhere?

C: Uh huh. I mean, I'm very sad about my mom, but I think this is about something else.

T: This is very important, what you are telling me. So, you're thinking there's something else, something we haven't addressed here or talked about?

C: Well… I'm not sure, but it just feels like the real problem is my life here and now is not the past (long pause). I'm really unhappy living at home with Dad because he doesn't seem to really care about me. It's like there's nobody to cares about me now, and that hurts (crying).

The client went on to explain how her father had changed following the death of her mother. Once warm and loving, he had become distant and cold. By the end of the visit, an agreement was made to invite the client's father into the sessions. Scores on the SRS were slightly higher than in previous sessions. Over the next few sessions together with the father, the woman's scores on the ORS began moving up, approaching and then slightly exceeding the green line. In sum, the ETR prompted an open and transparent dialogue about the lack of progress and exploration of alternatives. In this instance, altering the focus of services—a component of the therapeutic relationship—resulted in progress in subsequent sessions.

Improving the Outcome of Therapy One Person at a Time

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"It is better to take many small steps in the right direction than to make a great leap forward only to stumble backward."

Chinese Proverb

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The research evidence is clear: psychotherapy is an effective treatment for a wide range of presenting concerns and problems. At the same time, too many clients deteriorate while in care, an even larger number drop out before experiencing a reliable improvement in functioning, and outcomes vary widely and consistently among clinicians.

FIT uses routine, ongoing feedback regarding the client's perception of the therapeutic alliance and progress to guide and improve service delivery. A significant and growing body of research documents that, regardless of theoretical orientation or preferred treatment approach, employing FIT improves outcome and retention rates and reduces deterioration. In short, FIT improves the effectiveness of psychotherapy one person at a time.

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