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To cite this article: Wolfgang Lutz, Kim De Jong & Julian Rubel (2015): Patient-focused and feedback research in psychotherapy: Where are we and where do we want to go?, Psychotherapy Research, DOI: [10.1080/10503307.2015.1079661](https://doi.org/10.1080/10503307.2015.1079661)

To link to this article: <http://dx.doi.org/10.1080/10503307.2015.1079661>



Published online: 16 Sep 2015.



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## INTRODUCTION

# Patient-focused and feedback research in psychotherapy: Where are we and where do we want to go?

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### Abstract

In the last 15 years feedback interventions have had a significant impact on the field of psychotherapy research and have demonstrated their potential to enhance treatment outcomes, especially for patients with an increased risk of treatment failure. This article serves as an introduction to the special issue on “Patient-focused and feedback research in psychotherapy: Where are we and where do we want to go?” Current investigations on feedback research are concerned with potential moderators and mediators of these effects, as well as the design and the implementation of feedback into routine care. This introduction summarizes the current state of feedback research and provides an overview of the three main research topics in this issue: (1) How to implement feedback systems into routine practice and how do therapist and patient attitudes influence its effects?, (2) How to design feedback reports and decision support tools?, and (3) What are the reasons for patients to become at risk of treatment failure and how should therapists intervene with these patients? We believe that the studies included in this special issue reflect the current state of feedback research and provide promising pathways for future endeavors that will enhance our understanding of feedback effects.

**Keywords:** patient-focused-research; feedback ; outcome management; routine outcome monitoring (ROM); mediators and moderators

About two decades ago, *patient-focused* research (PFR) was introduced as a new research concept to outcome research in psychotherapy. Besides efficacy and effectiveness research, which are traditionally concerned with the average treatment effect of a given or new treatment approach, PFR is concerned with monitoring actual progress over the course of treatment and providing “real-time” feedback of this information to clinicians (Howard, Moras, Brill, Martinovich, & Lutz, 1996; Lambert, 2007; Lambert, Hansen, & Finch, 2001; Lutz, 2002).

Even though PFR is a relatively recent research area, it has become an international endeavor and one of the most prolific and cited areas within *Psychotherapy Research* over the last decades (Muran & Lutz, 2015). Starting with several large randomized controlled trials (RCTs), this research agenda, as well as its practical applications in routine care and the promising results of several studies, has been adopted in many countries and by several service

systems. Examples include the following: the USA (Bickman, Kelley, Breda, de Andrade, & Riemer, 2011; Lambert, Whipple et al., 2001; 2003); the UK (Barkham et al., 2001); Norway (Amble, Gude, Stubdal, Andersen, & Wampold, 2014); Germany (Lutz, Böhnke, & Köck, 2011); Sweden (Holmqvist, Philips, & Barkham, 2015); the Netherlands (De Jong, Van Sluis, Nugter, Heiser, & Spinhoven, 2012); and Australia (Newnham & Page, 2010).

This line of research has had a substantial impact on national and international policy decisions and research collaborations. Amongst others in the USA, the “APA Presidential Task Force on Evidence-Based Practice” stated that: “The application of research evidence to a given patient always involves probabilistic inferences. Therefore, ongoing monitoring of patient progress and adjustment of treatment as needed are essential” (American Psychological Association 2006, p. 280). In England, routine outcome monitoring (ROM) and

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feedback was a component in a government initiative to improve access to psychological treatments (“Improving Access to psychological Therapy,” IAPT; Clark et al., 2009). Most recently, the European research initiative stated in their roadmap for mental health research in Europe (ROAMER; Emmelkamp et al., 2014): “There is a clear need of research into routine outcome monitoring as a means of investigating the accountability of treatments, therapists and treatment centers” (p. 70). This broad international orientation is also reflected in the contributions of this special issue originating from six countries and three continents.

The development of PFR has been influenced by other movements within psychotherapy research and is related to ROM or practice-oriented research (POR). For example, in the most recent edition of the *Handbook for psychotherapy and behavior change*, Castonguay, Barkham, Lutz, and McAleavey (2013) differentiate practice-oriented research within psychotherapy into the three main approaches: patient-focused research, practice-based evidence, and practice research networks. PFR is based, as are scientist-practitioner networks and practice-based evidence, on the idea of an ongoing collaboration between practitioners and scientists (e.g., Boswell, Kraus, Miller, & Lambert, 2015; Castonguay & Muran, 2015; Holmqvist et al., 2015; Strauss et al., 2015). Practitioners deliver the actual treatment and collect data by assessing patients’ progress during therapy. This provides researchers with continuously growing databases of patients’ change information that can be utilized by researchers in pursuit of gaining a more thorough understanding of change patterns. In return, researchers have used this information to develop tools to support clinical decision making for clinical practice in real-time. The empirical progress or change information is directly fed back to therapists and patients as soon as it is available.

Feedback tools can be based on empirical data or rational decision strategies (e.g., Lutz, Stulz, Martinovich, Leon, & Saunders, 2014). They allow practitioners to track individual progress and adapt ongoing treatment, especially for patients with an early negative development (Lambert, 2007; Shimokawa, Lambert, & Smart, 2010). In that way, PFR establishes a permanent exchange between research and practice. Furthermore, data generated in projects following a patient-focused research paradigm can be used for supervision or can be used on a systems level as part of an evaluation or quality management system (e.g., Grossl, Reese, Norsworthy, & Hopkins, 2014; Swift et al., 2015). PFR methods and quality assurance (QA) or ROM in psychotherapy have formed a close relationship, although PFR,

QA, and ROM do not have identical goals, and do, sometimes, have divergent goals, especially when QA or ROM are established by legal institutions or regulations defining strategies of external quality control (as for example, in the Netherlands; Stuurgroep ROM ggz, 2010).

The pivotal goal of PFR is the use and implementation of research into the actual treatment and thereby making psychotherapy in clinical practice a research-supported intervention. In this view it is not enough that a treatment has been shown, on average, to be effective based on efficacy and effectiveness trials. Instead the research support should be an integral part of each individual treatment, to the extent that the current state of research as well as the service system and treatment environment allows it. As such, PFR follows an alternative concept of treatment development and research. Traditionally, the development of a new treatment concept starts with a new clinical idea proposed by a clinical researcher or practicing clinician. Based on this idea, a new treatment paradigm consisting of a number of interventions is developed and eventually tested in a RCT. If these efforts result in evidence suggesting that the new intervention is effective, often a new movement promoting the proposed clinical mechanisms of change starts to be disseminated. This is a natural development of how new theoretical concepts of change are introduced into the field, but often with limited empirical knowledge related to the actual moderators and mediators of change (Kazdin, 2014). In contrast, PFR supports a research-practice perspective that is more focused on the improvement of actual outcomes and less based on a debate about therapeutic schools or theories. Accordingly, the core of this approach requires research to be conducted on the course of individual patients in order to learn about differences in individual change as well as subgroups of patients with specific patterns of change (e.g., Lutz, et al., 2014; Rubel et al., 2014; Stulz, Lutz, Leach, Lucock, & Barkham, 2007).

The first three studies testing the effects of feedback were conducted by Michael Lambert and his research group (Lambert, Whipple et al., 2001; Lambert, Whipple, Vermeersch et al., 2002; Whipple et al., 2003). In these studies, feedback to therapists on patients’ progress was effective in improving patient outcomes, particularly for those patients who showed an increased risk for treatment failure (not on track patients; NOT). The percentage of NOT patients receiving feedback and reaching a reliable or clinical significant improvement was about 14% higher than the rate for the NOT patients without feedback. Furthermore, those NOT patients also had an 8% lower deterioration rate when their

therapists received feedback. Additionally, feedback to therapists of NOT patients led to, on average, longer treatments but shorter treatments, on average, for on-track (OT) patients. Further studies yielded more dramatic effects as a result of implementing feedback systems. Lambert and his group devoted considerable energy to predicting treatment failure (e.g., Lambert, Whipple, Bishop et al., 2002) and came to believe that the essential value of feedback systems was to help clinicians become aware of pending treatment failure, something that they could not achieve through clinical intuition (Hannan et al., 2005). From their perspective progress feedback is an intervention aimed at NOT cases, not all cases, and thus should be judged by its impact on such cases rather than the entire caseload. Thus, they developed and tested clinical support tools (CST) with decision rules for when and in which clinical areas therapists should intervene for patients at risk for treatment failure (e.g., Whipple et al., 2003).

To date, key findings of these original studies have been replicated under different conditions in many investigations and have been reported in four systematic reviews (Carlier et al., 2012; Davidson, Perry, & Bell, 2015; Krägeloh, Czuba, Billington, Kersten, & Siegert, 2015; Newnham & Page, 2010) and four meta-analyses (Knaup, Koesters, Schoefer, Becker, & Puschner, 2009; Lambert & Shimokawa, 2011; Poston & Hanson, 2010; Shimokawa et al., 2010). For example, in a recent review on the effects of feedback Krägeloh and colleagues (2015) reported that of the 25 identified studies, 17 showed a significantly positive feedback effect on average or for NOT patients. However, evidence for the effects of feedback on treatment length was less convincing. Of the 17 studies that reported on these associations, only six found a significant association between treatment length and feedback.

More detailed information about the size of the effects was derived from several meta-analyses (Lambert & Shimokawa, 2011; Shimokawa et al., 2010). In these studies the significant effect sizes regarding improvement for NOT patients with feedback vs. treatment as usual (TAU) offered by the same therapists ranged between  $g = .28$  (intent-to-treat sample, ITT) and  $g = .53$  (at least four sessions in treatment, efficacy analysis). For OT patients the effects were smaller, ranging from  $g = .18$  (ITT) to  $g = .32$  (efficacy analysis) if patients and therapists were provided with feedback and from  $g = .12$  (ITT) to  $g = .30$  (efficacy analysis) if only therapists received the feedback. When CST's were employed the effect size reached between  $g = .44$  (ITT) and  $g = .70$  (efficacy analysis; Shimokawa et al., 2010). The effect of psychometric feedback on treatment

length showed a heterogeneous picture, and the treatment length findings of the early studies could not be replicated, but the feedback effect on outcome was stable for different monitoring systems (OQ and PCOMS, see Lambert & Shimokawa, 2011).

Overall, over the last 10 years, feedback research has investigated a large variety of feedback modalities with regard to the feedback and monitoring systems used, the settings in which those were applied (e.g., child, group, couple, family, inpatient, outpatient, and counseling), the frequency with which feedback was provided during the course of treatment, the amount of information provided to clinicians (e.g., raw scores, expected treatment response curves, decision rules, and clinical support tools), the investigated diagnostic groups (e.g., eating disorders, addiction, and personality disorder), and the formalization of the usage of feedback. From this cumulative body of research we can conclude that feedback is effective, especially for not on track patients. Alerting therapists to patients at risk for treatment failure is essential for what needs to be fed back to therapists. Thus, evaluating the effects of feedback should focus on NOT cases. Furthermore, the accurate prediction of treatment failure is a condition of an effective feedback system and the feedback effects can be enhanced by using decision support tools, which include clinical suggestions to adapt or improve treatments with the risk of failure.

It can also be concluded, that the implementation of feedback systems leads to changes and adaptations in clinical interventions and is well received by patients. For example, in a German feedback study (Lutz et al., 2011; Lutz et al., 2015) on approximately 70% of the occasions, when therapists got feedback, therapists made some use of feedback either by taking some action or by drawing some consequence concerning their treatment formulation, for example, discussing the results with patients, trying to adjust their therapeutic interventions or trying to enhance the therapeutic alliance. Furthermore, the positive evaluations about feedback studies are very high. For example, when patients are asked, if they find it important to monitor the results of psychotherapeutic treatments, 66.8% answer with completely right and 26.1% of participants answer with partially right (further details see, e.g., Castonguay, et al., 2013; Lutz, et al., 2015; Strauss, et al., 2015). However, recent research has also shown that feedback is not equally effective for all therapists and patients. Simon, Lambert, Harris, Busath & Vazquez (2012) report that only for about 50% of the therapists feedback enhanced outcomes with NOT cases and had no impact for the other half of the therapists. Similarly, Lutz et al., (2015) analyzed therapist differences, which is an under investigated factor in feedback



studies so far. Results suggest that therapists satisfaction with the feedback system and their use of the feedback information are important differential predictors. Likewise, De Jong et al. (2012) analyzed differences between therapists in using feedback. Female therapists and those with a higher commitment to feedback seemed to have a higher probability to use the information provided by the feedback system. Those therapists, who used the feedback system, were also more effective for NOT patients.

Furthermore, the debate about giving feedback directly to patients compared to providing feedback just to therapists resulted in mixed results and it is still unclear whether giving formal written feedback to patients results in a further enhancement of outcome (De Jong et al., 2014; Shimokawa et al., 2010). Accordingly, nowadays the leading questions are more fine-grained than in the beginnings of feedback research: What are patient and therapist variables that moderate the effects of feedback? How should feedback be designed to maximize its effects? Which elements of feedback reports are more important and which are less important? How can therapists use feedback most efficiently? How can therapists be motivated and trained to integrate psychometric feedback in their work? How can we facilitate the implementation of ROM and feedback systems? These questions underpin the aims of this special issue.

Accordingly, the goal of this special issue in *Psychotherapy Research* is to present new studies related to those more specific and detailed research questions and to stimulate future work in this area. Authors were briefed that the issue was about the knowledge base around patient-focused research and feedback in psychotherapy. The studies could focus on the empirical basis of patient-focused research/feedback (when is it useful, does it improve clinical practice, what are the circumstances/predictors of its functionality, how does it work, what are the limitations) and/or could focus on data, which covers some aspects of a feedback systems (e.g., acceptability to clinicians, patients, and administrators), and/or could focus on the theoretical background and future research aspects of the field (e.g., fundamental part of clinical work, and required part of clinical training). They were also briefed that the focus was not on the presentation of a specific version of outcome monitoring systems and promotional material for specific instruments. By contrast, the focus of the current special issue was on cutting-edge original articles that showed the current status as well as the pros and cons of the research field. Another important feature was that articles in the special issue should reflect the international perspective in this research field. Therefore, experts from six countries and

three continents, working with different feedback systems were invited.

In addition to this introduction, the special issue comprises nine empirical papers investigating the most up to date research questions within the following areas of PFR:

- How to implement feedback systems into routine care and how do therapist and patient attitudes influence its effects? Implementation, acceptance, and feasibility of routine outcome monitoring.
- How to design feedback reports and decision support tools? The important elements of feedback reports.
- What are the reasons that patients are not on track or at risk for treatment failure? In which clinical areas should therapists get feedback, and how to intervene? Typical problems of patients who do not profit from treatment or are at risk for failure, dimensions of feedback and clinical support tools.

#### **How to Implement Feedback Systems into Routine Care and How Do Therapist and Patient Attitudes Influence its Effects?**

The first four papers address questions related to the implementation of feedback in routine care as well as feasibility and acceptance issues (Amble, Gude, Stubdal et al., 2014; De Jong & Goede, 2015; Lucock et al., 2015; Lutz et al., 2015). In the first study, Lucock et al. (2015) present an empirical investigation of these questions. Using an actual study example within the UK National Health Service, the authors identified barriers and facilitators of an effective implementation of outcome monitoring and feedback systems with a mixed methods approach. In this study, therapists were asked to complete quantitative questionnaires and their written and verbal feedback was subjected to qualitative thematic analyses. While their findings generally support the feasibility and acceptability of the implementation of ROM, the authors emphasize apparent therapist differences. These findings underline the importance of the participating therapists in feedback studies. In the second paper, taking the importance of therapist differences into account, Lutz et al. (2015) examine therapist effects on treatment outcome and treatment length in a German feedback study. In an outpatient sample treated in private practices, the authors consider several predictors of treatment outcome and length. Therapists' attitudes (a composite index of feedback usage and satisfaction with the feedback system) as well as patients' attitudes toward psychometric feedback influence the impact of feedback on

outcome. In the third article, De Jong and De Goede (2015) report a feasibility study to explore two potential factors influencing therapists' attitude formation as well as treatment outcome in three outpatient mental healthcare centers in the Netherlands. The first factor investigated whether a therapists' regulatory focus—that is whether she/he is rather motivated to prevent failure or to achieve success. The second factor is the perceived match between the therapist's own values and the philosophy of the organization she/he is working in.

The last of these studies investigates the impact and consequences of a multisite implementation of the OQ feedback system in southern Norway (Amble, Gude, Stubdal et al., 2014). In six psychiatric clinics, the authors evaluate the implementation within a multisite randomized clinical trial design. Besides the overall effects of feedback, the authors investigate whether these effects differ between the sites and with regard to the treatment course of the patient (OT vs. NOT). Based on that study, Amble, Grude, Ulvenes, Stubdal, and Wampold (2015) investigated whether receiving a signal for NOT cases causes the effect of feedback.

### **How to Design Feedback Reports and Decision Support Tools?**

The second topic in this issue, as well as a major theme within PFR, is the actual design of feedback reports. Decision support tools play a crucial role in efforts to enhance the effects of feedback. Therefore, the next three papers of this special issue investigate specific elements of feedback reports and try to identify the essential clinically useful information that helps to improve patient outcomes (Crits-Christoph et al., 2015; Douglas et al., 2015; Restifo, Kashyap, Hooke, & Page, 2015).

The first of these papers searched for the mechanisms through which feedback leads to more pronounced treatment effects. Douglas et al. (2015) hypothesize that therapists who receive feedback on the problems of their patients address specific contents more immediate and more frequently than without feedback. The authors use data from clients treated within a home-based community mental health treatment. Therapists were provided with computerized feedback on the problem areas of their patients. Such problem-specific feedback is consistent with the results of a recent study providing evidence for an enhanced feedback effect if feedback is based on multiple domains in comparison to a single domain (Dyer, Hooke, & Page, 2014).

In order to evaluate the progress of patients over the course of treatment and to give feedback, decision

tools that compare the actual progress to a benchmark are necessary. Since the early days of feedback studies, decision tools or expected treatment response (ETR) curves based on data of already treated patients are investigated. Early studies using mostly initial impairment as the basis for ETR resulted in about 17–18% of explained variance in the rate of change (e.g., Lambert, Whipple, Bishop et al., 2002; Lutz, Martynovich, & Howard, 1999), whereas additional predictors such as previous therapy, chronicity and treatment expectation added only a small additional amount of explained variance to the ETR curves (e.g., 22% in Lutz et al., 1999). This topic is addressed in the next article by Crits-Christoph et al. (2015) that focuses on predictors of ETR curves for patients treated in four US community-based outpatient substance abuse treatment clinics. General intake variables, such as the initial score in the OQ-45, as well as substance abuse specific variables (e.g., craving) were investigated with regard to their associations with patients' change curves. Specifically, the results were used to deduce implications for the design of ETR curves in disorder specific settings (e.g., substance abuse treatments; also see Schuman, Slone, Reese, & Duncan, 2014).

In the next article, Restifo et al. (2015) present an innovative application of ROM and feedback for the prediction of self-harming behaviors following suicidal ideation. Using latent class growth analysis, the authors identify change patterns of suicidal ideation in psychiatric inpatients. The authors investigate whether and how information on typical change patterns could be used in routine inpatient care to estimate the probability that suicidal ideation results in self-harming behaviors and how this tool could be used to avoid self-harm.

### **What are the Reasons that Patients are Not on Track or at Risk for Treatment Failure?**

The final two papers deal with the reasons why patients get off track and in which areas therapists should intervene to prevent treatment failure (Probst et al., 2014; White et al., 2015). As described above, clinical support tools (CSTs) for patients that are NOT allow therapists to tailor their interventions and therefore appear to enhance the effect of feedback. Both papers in this section take a closer look at patients' typical response patterns on therapy process measures typically used in CSTs. Probst et al. (2014) compare the scores in the Assessment for Signal Clients (ASC; Lambert, 2007) scales of patients with extreme positive deviations from the above-discussed ETR curves with those of patients with extreme negative deviations. Using this approach with patients from a

psychosomatic inpatient clinic in Germany, the authors investigate whether prioritizing the ASC domains (therapeutic alliance, social support, motivation, and life events) could further enhance the effects of clinical support tools. In the same vein, White et al. (2015) investigate ASC data of cases that were identified as NOT in a feedback study carried out in a hospital-based outpatient clinic in the USA. The ASC was completed immediately after the identification of a patient as being at risk for treatment failure. These ASC data were subjected to a cluster analysis to characterize typical patterns of problem areas within these signal clients. Knowing typical problem areas and/or conjoint problem areas of patients who do not profit from therapy in the first place, again allows the development of more effective support tools for important domains. This area of investigation, which focusses on the further refinement of the clinical support tools, seems to be another promising area of future investigations.

In sum, this special issue provides an overview of new developments in the field of patient-focused and feedback research that we hope will inspire new, innovative studies and research collaborations. We believe that the studies included in this special issue reflect the current state of feedback research and flag promising pathways for future endeavors that will increase our understanding of feedback effects. Feedback tools can and will likely be more easily implemented in the future by using tools from eMental health research (e.g., Emmelkamp et al., 2014). The more technology develops, the easier it is to implement these tools into daily routine. Given that 20 years ago psychotherapy research was limited to a few patients treated in a university setting and assessed in a pre-post design, this new line of research allows us to study psychotherapy in practice, based on large databases and to integrate this information directly into the field, while promoting further integration of science and practice. Thus, the implementation of feedback in the training and supervision of future therapists would help them to build a clinical identity, which includes research as an integral part of the treatment.

### Acknowledgement

We would like to thank Michael J. Lambert and Michael Barkham for commentaries on previous versions of this manuscript.

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