Solution Focused Therapy, Common Factors, and the Partners for Change Outcome Management System: A Ménage à Trois Made in Heaven

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To exchange one orthodoxy for another is not necessarily an advance. The enemy is the gramophone mind, whether or not one agrees with the record that is being played at the moment.
George Orwell

Solution Focused Brief Therapy (SFBT; de Shazer, 1985, 1994), like much of family therapy, emerged from a climate of theoretical and practical skepticism and intense interest in the mechanisms of therapeutic change. There was a growing disillusionment with psychodynamic therapy, and out of this dissatisfaction emerged a desire to find new ways of doing therapy briefly. This search eventually evolved into the cadre of brief, systemic, contextual approaches that despite divergent influences, had common themes: 1) a shift from the individual to relationship, interaction, and context: 2) a shift toward active, responsive intervention; 3) a shift toward client-specific versus theory-specific intervention; and 4) a gradual movement toward therapy as an evolving, co-constructed conversation.

It is worth taking note of the persons and ideas that inspired much of the work depicted in this book. The Bateson project's double-bind theory of schizophrenia (Bateson, Jackson, Haley, & Weakland, 1956) suggested that the communication of people considered schizophrenic "made sense" in the context of conflicting and paradoxical injunctions prevalent in the person's social system, the family. The Bateson project contributed the cornerstone of a burgeoning brief therapy movement—that problems can be understood in the context of communicative interaction in significant relationships.

Jay Haley and John Weakland's prolific study of Milton Erickson's work spawned

strategic brief therapy (Haley, 1973), and significantly influenced both the interactional approach of the Mental Research Institute (MRI; Watzlawick, Weakland, & Fisch, 1974) and SFBT (de Shazer, 1982). Chief among these influences were Erickson's insistence that therapists should tailor their approach to fit the client's unique worldview, expectations, and preferred method of working. Second, rather than approaching psychological distress as deficit, Erickson highlighted the client's abundant storehouse of resources, challenging therapists to pursue and magnify resources, rather than disabilities. Third, Erickson demonstrated that change can happen quickly and often in dramatic, unexpected ways.

SFBT, the most influential of the brief approaches emerging out of that era of innovation continues to evolve as evidenced by this book and other recent contributions (e.g., Isebaert, 2016). Inherent in SFBT is the fundamental faith that clients can and will realign the parts of their lives that are distressing, given the powerful context of a relationship that respects and follows clients' lead. It takes seriously research that, over and over, places clients as the prime movers in therapy and the therapeutic alliance as the fuel for that movement--the client is the heart and the alliance is soul of therapeutic change (Duncan, 2014). Although the word "research" may evoke visions of pencil headed geeks with no lived connection to the therapy experience, SFBT practitioners may be interested to discover that research adamantly supports solution focused ideas and practices. That is the topic of this chapter.

A story illustrates the sentiments that many practitioners feel about research. Two researchers were attending their annual conference. Although enjoying the proceedings, they decided to find some diversion to combat the tedium of sitting all day and absorbing vast amounts of information. They settled on a hot air balloon ride and were quite enjoying themselves until a mysterious fog rolled in. Hopelessly lost, they drifted for hours until finally a

clearing in the fog appeared and they saw a man standing in an open field. Joyfully, they yelled down at the man, “Where are we?” The man looked at them, and then down at the ground, before turning a full 360 degrees to survey his surroundings. Finally, after scratching his beard and what seemed to be several moments of facial contortions reflecting deep concentration, the man looked up and said, “You are above my farm.”

The first researcher looked at the second researcher and said, “That man is a researcher—he is a scientist!” To which the second researcher replied, “Are you crazy? He is a simple farmer!” “No,” answered the first researcher emphatically, “that man is a researcher and there are three facts that support my assertion: First what he said was absolutely 100% accurate; second, he systematically addressed our question through an examination of all of the empirical evidence at his disposal, and then carefully deliberated before delivering his conclusion; and finally, the third reason I know he is a researcher is that what he told us is absolutely useless to our predicament.”

The research presented in this chapter, hopefully, will be useful to your predicament. After a discussion of the most replicated finding of the therapy literature, the dodo bird verdict, this chapter describes the common factors of change and their perfect fit with SFBT. This chapter also suggests that SFBT therapists can enhance their positive outcomes by piggybacking on their use of scaling questions with more formal feedback measures about the benefit and fit of services, a process that arose partially from SFBT called the Partners for Change Outcome Management System (PCOMS; Duncan, 2012; Duncan & Reese, 2015a; Duncan & Sparks, 2018).

But first, another story illustrates the thematic connection among SFBT, the common factors, and PCOMS. A long time ago in a galaxy far way, I was in my initial clinical placement

in graduate school at the local state hospital. This practicum was largely, if not totally, intended to be an assessment experience. Tina, my first client ever, was like a lot of the clients: young, poor, disenfranchised, heavily medicated, and on the merry-go-round of hospitalizations—and at the ripe old age of 22, she was called a "chronic schizophrenic."

I gathered up my WAIS (Wechsler Adult Intelligence Scale), the first of the battery of tests I was attempting to gain competence with, and was on my merry but nervous way to the assessment office, a stark, run-down room in a long past its prime, barrack-style building that reeked of cleaning fluids over-used to cover up some other worse smell, the institutional stench. But on the way I couldn't help but notice all the looks I was getting—a smirk from an orderly, a wink from a nurse and funny looking smiles from nearly everyone else. My curiosity piqued, I was just about to ask what was going on when the chief psychologist put his hand on my shoulder and said, "Barry, you might want to leave the door open." And I did.

I greeted Tina, an extremely pale young woman with short brown, cropped hair, who might have looked a bit like Mia Farrow in the Rosemary's Baby era had Tina lived in friendlier circumstances, and introduced myself in my most professional voice. And before I could sit down and open up my test kit, Tina started to take off her clothes, mumbling something indiscernible. I just stared in disbelief, in total shock really. Tina was undaunted by my dismay and quickly was down to her bra and underwear when I finally broke my silence, hearing laughter in the distance, and said, "Tina, what are you doing?" Tina responded not with words but with actions, removing her bra like it had suddenly become very uncomfortable. So there we were, a graduate student, speechless, in his first professional encounter, and a client sitting nearly naked, mumbling now quite loudly but still nothing I could understand, and contemplating whether to stand up to take her underwear off or simply continue her mission while sitting.

Finally, in desperation, I pleaded, “Tina, would you please do me a big favor? I mean I would really appreciate it.” She looked at me for the first time and said, “What?” I replied, “I would really be grateful if you could put your clothes back on and help me get through this assessment. I’ve done them before, but never with a client, and I am kinda freaked out about it.” Tina whispered, “Sure,” and put her clothes back on, and completed the testing.

I was so appreciative of Tina’s help that I told her she really pulled me through my first real assessment. She smiled proudly, and ultimately smiled at me every time she saw me from then on. I wound up getting to know Tina pretty well and often reminded her how she helped me. The more I got to know Tina and realized that her actions, stemming from horrific abuse, were attempts to take control of situations in which she felt powerless, the angrier I became about her being used as a rite of passage for the psychology trainees—a practice that I stopped.

I’ll never forget the lessons that Tina taught me in the very beginning of my psychotherapy journey: authenticity matters and when in doubt or in need of help, ask the client because you are in this thing together. Those lessons weave throughout this chapter, and are intimately related to SFBT, the common factors, and PCOMS.

The Dodo Bird Verdict: The Differential Effectiveness of Competing Therapies

If a man (sic) will kick a fact out of the window, when he comes back he finds it again in the chimney corner.

Ralph Waldo Emerson

In the children’s classic, *Alice in Wonderland* (1865/1962), Lewis Carroll wrote of a race intended to help dry the animals after they were soaked by Alice’s homesick tears. The animals ran off helter skelter in different directions, and the race was soon stopped after all were quickly exhausted. The animals demanded that the dodo proclaim a winner of the race until at last he

exclaimed the now famous verdict, “Everybody has won, and all must have prizes.” An inspection of Saul Rosenzweig’s prophetic (1936) article, “Implicit Common Factors in Diverse Forms of Psychotherapy,” reveals the quote by the dodo bird used as an epigraph (see Rosenzweig’s original article as well as his commentary about it in Duncan, 2010). The dodo’s pronouncement was cleverly invoked to describe the equivalence of effectiveness among the psychotherapies of Rosenzweig’s day; it has since become a metaphor for the consistent finding that all approaches work about equally well.

The dodo’s judgment remains the best description of the data--the most replicated finding in the psychological literature—encompassing a broad array of research designs, problems, populations, and clinical settings (Duncan, Miller, Wampold, & Hubble, 2010). Among many examples, a study in the UK (Stiles, Barkham, Twigg, Mellor-Clark, & McConnell, 2008) provides yet another: Comparing cognitive behavioral therapy (CBT), psychodynamic therapy (PDT), and person centered therapy (PCT) as routinely practiced, the largest naturalistic study of effectiveness ever conducted (over 5000 clients), once again, found no differences among the investigated approaches.

The idea that change primarily emanates from the model or techniques you wield is a siren call destined to smash you against the jagged rocks of ineffective therapy. That therapists might possess the psychological equivalent of a “pill” for emotional distress resonates strongly with many, and is nothing if not seductive as it teases our desires to be helpful. A treatment for a specific “disorder,” from this perspective, is like a silver bullet, potent and transferable from research setting to clinical practice. Any therapist need only to load the silver bullet into any psychotherapy revolver and shoot the psychic werewolf stalking the client. In its most unfortunate interpretation, clients are reduced to a diagnosis and therapists defined by a treatment

technology—both interchangeable and insignificant to the procedure at hand. This product view of psychotherapy is most empirically vacuous because the treatment itself accounts for so little of outcome variance, while the client and the therapist—and their relationship—account for so much more.

In truth, we are easily smitten by the lure of flashy techniques. Amid explanations and remedies aplenty, therapists courageously continue the search for designer explanations and brand name miracles—disconnected from the power for change that resides in the pairing of two unique persons, the application of strategies that resonate with both, and the impact of a quality partnership. This, of course, doesn't mean that SFBT or any technique is unimportant but rather that it is delivered among a constellation of other factors that are often taken for granted but actually are more important to outcome. The dodo verdict is not a criticism of a solution focused model or any others but rather simply draws our attention to the common factors of change—which happen to go hand in glove with solution focused practice.

What Works: The Common Factors and SFBT

What…accounts for the result that apparently diverse forms of psychotherapy prove successful in similar cases? Or if they are only apparently diverse, what do these therapies actually have in common that makes them equally successful?…it is justifiable to wonder…whether the factors that actually are in operation in several different therapies may not have much more in common than have the factors alleged to be operating.

Saul Rosenzweig

Rosenzweig (1936) not only predicted 80 plus years of data, he presented the classic argument, still used today, for a common factors perspective—namely, because all approaches appear equal in effectiveness, there must be pantheoretical factors in operation that overshadow

any perceived or presumed differences among approaches. In short, he discussed the factors common to therapy as an *explanation* for the comparable outcomes of varied approaches. Writing in the *American Journal of Orthopsychiatry*, Rosenzweig observed that no form of psychotherapy or healing is without cures to its credit. Concluding that success is therefore not a reliable guide to the validity of a theory, he suggested that some potent implicit common factors, perhaps more important than the methods purposely employed, explained the uniformity of success of seemingly diverse methods. Rosenzweig's four-page article is still well worth the read (and available at https://heartandsoulofchange.com).

If Rosenzweig penned the first notes of a common factors chorus, Johns Hopkins University's Jerome Frank composed an entire symphony. Frank (1973) identified four features shared by all effective therapies: (a) an emotionally charged, confiding relationship with a helping person, (b) a healing setting, (c) a rationale, conceptual scheme or myth that provides a plausible explanation for the client's symptoms and prescribes a ritual or procedure for resolving them, and (d) a ritual or procedure that requires the active participation of both client and therapist and that is believed by both to be the means of restoring the client's health. Frank's work is particularly helpful, as noted below, in understanding the role of model and technique as the vehicle for delivering the other factors.

Several others have identified these elements found in all therapies, but Brigham Young University's Michael Lambert deserves special mention. After an extensive analysis of decades of outcome research, Lambert (1986, 2013) identified four factors—and their estimated percentages of outcome variance—as the principal elements accounting for improvement: extratherapeutic (hereafter client/life) variables (40%), relationship factors (30%), hope, expectancy, and placebo (15%), and model/technique (15%). Although these factors are not

derived from a statistical analysis, he suggested that they embody what studies indicated about treatment outcome. Lambert's portrayal of the common factors bravely differentiated factors according to their relative contribution to outcome, opening a new vista of understanding models and their proportional importance to success—a bold challenge to their revered status.

Inspired by Lambert's proposal and our roots in Ericksonian, interactional, and solution focused therapies, my colleagues and I (Duncan & Moynihan, 1994; Duncan, Solovey, & Rusk, 1992) proposed a "client directed" perspective to apply the common factors based on their differential impact on outcome. "Client directed" spoke to the power of client factors as well as the privilege that should be afforded to client ideas and theories, view of the alliance, and preferences about intervention; intervention effectiveness was described as dependent on rallying client resources and as a tangible expression of the quality of the alliance. I have been attempting to further operationalize the factors ever since (e.g., Duncan, 2014). The common factors help us take a step back and get a big picture view of what really works, suggesting that we spend our time in therapy commensurate to each element's differential impact on outcome.

Recent findings from meta-analytic studies as well as more attention to therapist variance paint a more complicated but satisfying representation of the different factors, their effects, and their relationship to each other. Lambert's "pie chart" view of the common factors incorrectly implies that the proportion of outcome attributable to each was static, separate, and could be added up to 100% of therapy effects. In truth, the factors are interdependent, fluid, dynamic, and dependent on who the players are and what their interactions are like.

Five factors comprise this perspective: client, therapist, alliance, model/technique (general and specific effects), and feedback—all interdependent and overlapping.

Client/Life Factors

...it is the client more than the therapist who implements the change process…we need to reform our thinking about the efficacy of psychotherapy. Clients are not inert objects or diagnostic categories on whom techniques are administered. They are not dependent variables on which independent variables operate…people are agentive beings who are effective forces in the complex of causal events.

Lambert, Garfield, and Bergin (2004)

To understand the common factors, it is first necessary to separate the variance due to psychotherapy from that attributed to client/life factors, those variables incidental to the treatment model, idiosyncratic to the specific client, and part of the client's life circumstances that aid in recovery despite participation in therapy (Asay & Lambert, 1999)—everything about the client that has nothing to do with us.

Figure 1 offers my thinking about the factors derived from meta-analytic research, trying to make sense of their different but overlapping proportions of the variance of change.

Insert Figure 1 about here

Calculated from the often reported 0.80 effect size of therapy, the proportion of outcome attributable to treatment (14%) is depicted by the small circle nested within the larger circle at the lower right side of the left circle in Figure 1. The remaining variance accounted for by client factors (86%), including unexplained and error variance is represented by the large circle on the left. Even a casual inspection reveals the disproportionate influence of what the client brings to therapy. More conservative estimates put the client's contribution at 40% (Lambert, 2013). As

examples, persistence, faith, a supportive grandmother, depression, membership in a religious community, divorce, a new job, a chance encounter with a stranger, a crisis successfully managed all may be included. Although they are hard to research because of their idiosyncratic nature, these elements are the most powerful of the common factors—the client is the engine of change (Bohart & Tallman, 2010).

The impact of client/life factors on outcome makes even more curious the adoption of pathological descriptions of clients. Duncan (Duncan, 2002; Duncan & Miller, 2000a) debunks the cult of client incompetence and exposes the field's hidden assumptions—the heroic psychotherapist galloping in on the white stallion of theoretical clarity brandishing a sword of empirically supported treatments to rescue the helplessly disordered patient terrorized by the psychic dragon of mental illness—and calls for a "recasting" of the therapeutic drama to assign clients their rightful "heroic" roles in change.

In the absence of compelling evidence for any specific variables that cut across clients to predict outcome or account for the unexplained variance, this most potent source remains largely uncharted. Client factors cannot be generalized because they differ with each client. These unpredictable differences can only emerge one client at a time, one alliance at a time, one therapist at a time, and one treatment at a time. But we do know something for sure: If we don't recruit these idiosyncratic contributions to outcome in service of client goals, we are inclined to fail. Indeed, in a comprehensive review of 50 years of literature for the 5th Edition of the *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change*, Orlinsky, Rønnestad, and Willutzki (2004) indicate, "the quality of the patient's participation . . . [emerges] as the *most* important determinant of outcome" (p. 324; emphasis added).

Rallying clients and their resources to the cause of change is perhaps what SFBT does best, intentionally combing the client's experience in search of existing strengths and solutions. Looking at exceptions, when temptations are overcome, when things are going well, or when the problem isn't occurring all shine a spotlight on client resources, illuminating possibilities for solution. Attending to client factors is the sine qua non of solution focused practice--enlisting, recruiting, or harvesting client resources in service of client goals (Murphy & Duncan, 2010). Interestingly, as we will see below, this "focus" is one of the distinguishing factors of better therapists.

Figure 1 also illustrates the second step in understanding the common factors. The second, larger circle in the center depicts the overlapping elements that form the 14% of variance attributable to treatment. Visually, the relationship among the common factors, as opposed to a static pie-chart depicting discreet elements adding to a total of 100%, is more accurately represented with a Venn diagram, using overlapping circles and shading to demonstrate mutual and interdependent action. The factors, in effect, act in concert and cannot be separated into disembodied parts (Duncan et al, 1992).

To exemplify the various factors and their attending portions of the variance, the tried and true Treatment of Depression Collaborative Research Program (TDCRP) (Elkin et al., 1989) will be enlisted. The TDCRP randomly assigned 250 depressed participants to four different conditions: CBT, interpersonal therapy (IPT), antidepressants plus clinical management (IMI), and a pill placebo plus clinical management. The four conditions—including placebo—achieved about the same results, although both IPT and IMI surpassed placebo (but not the other treatments) on the recovery criterion (yet another example of the dodo verdict). Although the

TDCRP is now over twenty-five years old, the data continue to be analyzed and relevant, as we will see below.

Therapist Effects

Since no one method of therapy has a monopoly on all the good therapists, another potentially common factor is available to help account for the equal success of avowedly different methods.

Saul Rosenzweig

Therapist effects represent the amount of variance attributable not to the model wielded, but rather to *whom* the therapist is—it's no surprise that the participants in the therapeutic endeavor account for the lion share of how change occurs. Depending on whether therapist variability is investigated in efficacy or effectiveness studies, a recent meta-analysis suggested that 5-7% of the overall variance is accounted for by therapist effects (Baldwin & Imel, 2013). This is a conservative finding compared to earlier estimates that suggested that at least 8% of the variance is accounted for by therapist factors, including the TDCRP (Kim, Wampold, & Bolt, 2006) and a recent investigation by my Project colleagues and me (Owen, Duncan, Reese, Anker, & Sparks, 2014). Therefore, in Figure 1, a 5-8% range is depicted or 36-57% of the variance (the 14%) attributed to treatment[1]. The amount of variance, therefore, accounted for by therapist factors is about five to eight times more than that of model differences. In many respects, you *are* the treatment. The psychiatrists in the TDCRP illustrate—the clients receiving sugar pills from the top third most effective psychiatrists did better than the clients taking antidepressants from the bottom third, least effective psychiatrists (Kim et al., 2006). *Who* was providing the medication or sugar pill was far more important than *what* the pill contained.

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[1] The percentages are best viewed as a defensible way to understand outcome variance but not as representing any ultimate truths. They are meta-analytic estimates of what each of the factors contributes to change. Because of the overlap among the common factors, the percentages for the separate factors will not add to 100%.

What accounts for the variability? One possibility, and building on the Orlinsky et al. (2004) quote above is what Gassman and Grawe (2006) called *resource activation v. problem activation*. They conducted minute-by-minute analyses of 120 sessions involving 30 clients treated for a range of psychological problems. They found that unsuccessful therapists focused on problems while neglecting client strengths. When the unsuccessful therapists did focus on clients' strengths, they did so more at the end of a therapy session. Successful therapists focused on their clients' strengths from the very start. They immediately activated client resources to address client problems.

And the absolute certainty? The most definitive thing we know about what makes some therapists better than others is their ability to secure a good alliance across a variety of client presentations and personalities—even the tough ones. For example, Baldwin, Wampold, & Imel (2007) found that therapists who generally form better alliances also had better outcomes. Baldwin et al. (2007) dispelled common folklore by demonstrating that good alliances were more of a function of what therapists brought to the table than clients; i.e., more effective therapists adept at alliances were able to transcend type of client while other less effective therapists were not. There is really no mystery here. The answer to the oft heard question about why some therapists are better than others is that tried and true but taken for granted old friend, the therapeutic alliance.

These two areas, what Gassman and Grawe called *resource activation,* and securing strong alliances with more clients, even the hard ones, likely represent the best ways to create positive outcomes, regardless of therapist orientation. Once again, SFBT naturally incorporates resource activations and also appears to have a leg up regarding the alliance, as a further examination will reveal.

The Alliance

. ...observers seem intuitively to sense the characteristics of the good therapist time and again…sometimes being so impressed as almost to believe that the personality of the therapist would be ***sufficient*** *[emphasis added] in itself, apart everything else, to account for the cure of many a patient by a sort of catalytic effect.*

Saul Rosenzweig

Researchers repeatedly find that a positive alliance—an interpersonal partnership between the client and therapist to achieve the client's goals (Bordin, 1979)—is one of the best predictors of outcome. Historically, the amount of variance attributed to the alliance has ranged from 5% to 7% of overall variance or 36-50% of the variance accounted for by treatment (e.g., Horvath, & Bedi, 2002). More recently, Horvath, Del Re, Flückiger, and Symonds (2011) examined 201 studies and found the alliance to account for a slightly higher 7.5% of the variance. Putting this into perspective, the amount of change attributable to the alliance is about five to seven times that of specific model or technique.

Despite this, however, naysayers will dismiss the alliance by saying the research is only correlational. This is like saying that smoking cigarettes is only correlated with lung cancer! Even more damning, they say, is that we don't know which comes first, client experience of a strong alliance or client report of change or benefit—the classic chicken or the egg question. Our alliance study of 500 clients (Anker, Owen, Duncan, & Sparks, 2010) directly addressed this question. The alliance significantly predicted outcome over and above substantial early change, demonstrating that the alliance is not merely an artifact of client improvement but rather a force to be reckoned with in and of itself.

Finally, Krupnick et al. (1996) analyzed data from the TDCRP and found that the

alliance, from the client's perspective, was predictive of success for all conditions—the treatment model was not. Mean alliance scores explained up to 21% of the variance, while treatment differences accounted for nearly 0% of outcome variance (Wampold, 2001). Keep in mind that treatment accounts for, on average, 14% of the variance (see Figure 1). The alliance in the TDCRP explained more of the variance by itself, illustrating how the percentages are not fixed and depend on the particular context of client, therapist, alliance, and treatment model.

The alliance as classically defined by Bordin (1979) includes the relational bond between the therapist and client as well as their agreement about the goals and task of therapy. Although much ignored, it is a fact that the alliance is our most powerful ally and represents the most influence we can have over outcome. The problem is that the alliance is not sexy in comparison to promises of "miracle cures" and "outcomes light years ahead" that often permeate the therapy field. But the alliance is not the anesthesia before surgery—it's not the stuff you do until you get to the real therapy. We do not offer Rogerian reflections to lull clients into complacency so we can stick the real intervention to them! The alliance is probably best conceptualized as an all-encompassing framework for psychotherapy—it transcends any specific therapist behavior and is a property of all aspects of providing services (Hatcher & Barends, 2006). The alliance is therefore evident in anything and everything you do to engage the client in purposive work, from offering an explanation or technique to scheduling the next appointment. You have to *earn* the alliance—it's not given to you—with every individual, a daunting task to be sure.

SFBT inherently brings significant attention to the alliance in several ways. SFBT embraces relational concepts such as empathy and positive regard via attention to validating and complimenting clients as well as a concerted effort to highlight what's right with clients as opposed to what's wrong with them (Duncan, 2005). Seeing clients as capable helps engage

clients in the work. Perhaps where solution focused practices have been in the forefront of securing good alliances, however, has been with its attention to agreement with the client about the goals and the tasks of therapy—what you are going to work on and how you are going to do it. Tenaciously following client goals and mining solutions from client experience all but guarantees the required agreement about the goals and tasks of therapy.

In an important way, the alliance is dependent on the delivery of some particular treatment—a framework for understanding and solving the problem. There can be no alliance without treatment, a plan, in other words, to address the client's difficulty. On the other hand, technique is only as effective as its delivery system—the client-therapist relationship. If technique fails to engage the client in purposive work, it is not working properly and a change is needed. If the search for exceptions or a strength-based perspective does not inspire the client's participation, for example, then, as good as those ideas are, they are not useful with that client. Here is where the variety of models and techniques pays off.

While there is no differential efficacy among approaches in general, there is differential effectiveness among approaches with the client in your office *now*. The question is: does the approach resonate or not? Does its application help or hinder the alliance? Is it something that both you and the client can get behind? Your alliance skills are truly at play here—your interpersonal ability to explore the client's ideas, discuss options, collaboratively form a plan, and negotiate any changes when benefit to the client is not forthcoming. Technique, its selection and application, in other words, are instances of the alliance in action.

The issue of resonance and the agreement about tasks—finding a framework for therapy that both you and the client can believe in—is why it makes a lot of sense to ask clients about their ideas about how to proceed, or at the very least getting client approval of any intervention

plan. Traditionally, such a process has not been the case—the search has been for interventions that promote change by validating the therapist's favored theory. Serving the alliance requires taking a different angle—the search for ideas that promote change by validating the client's view of what is helpful—the *client's theory of change* (Duncan et al., 1992; Duncan & Miller, 2000b; Duncan & Moynihan, 1994).

Again recall the TDCRP. Clients' perceptions of treatment match with their beliefs about the origin of their depression and what would be helpful (psychotherapy or medication), contributed to early engagement, continuation in therapy, and the development of a positive alliance (Elkin et al., 1999).

Model/Technique: Specific and General Effects (Explanation and Ritual), Client Expectancy (Hope, Placebo), and Therapist Allegiance

Whether the therapist talks in terms of psychoanalysis or Christian Science is from this point of view relatively unimportant as compared with the formal consistency with which the doctrine employed is adhered to, for by virtue of this consistency the patient receives a schema for achieving some sort and degree of personality organization.

Saul Rosenzweig

Model/technique factors are the beliefs and procedures unique to any given treatment. They offer an explanation for the client's difficulties, and establish methods for resolving them. Because comparisons of therapy techniques have found little differential efficacy, they may all be understood as healing rituals—technically inert, but nonetheless powerful, organized methods for enhancing the effects of client expectations for change—the so-called and perhaps poorly-named "placebo" factors. Whether soliciting exceptions, or instructing clients to talk to an empty chair, or chart negative self-talk, mental health and substance abuse professionals are engaging in

healing rituals.

But these specific aspects, the impact of the differences among treatments, are very small, only about 1% of the overall variance or 7% of that attributable to treatment. But the *general effects* of delivering a treatment are far more potent. Most therapeutic methods or tactics share the common quality of preparing clients to take some action to help themselves. In particular, therapists expect their clients to do something different—to develop new understandings, feel different emotions, face fears, or alter or reinstate old patterns of behavior. In short, model and technique provide a structure and focus for both the client and therapist to navigate the waters of change.

As Frank (1973) seminally noted, all models include a rationale or myth, an explanation for the client's difficulties, and a procedure or ritual, strategies to follow for resolving them. Models achieve their effects, in large part, if not completely *through* the activation of placebo, hope, and expectancy, combined with the therapist's belief in (allegiance to) the treatment administered. As long as a treatment makes sense to, is accepted by, and fosters the active engagement of the client, the particular approach used is unimportant. Said another way, therapeutic techniques are placebo-delivery devices (Kirsch, 2005).

In both medicine and psychotherapy, when the placebo or technically inert condition is offered in a context that creates positive expectations, it reliably produces effects almost as large, or as large as the treatment itself (Wampold, Minami, Tierney, Baskin, & Bhati, 2005). The TDCRP is again instructive. First, across all conditions, client expectation of improvement predicted outcome (Sotsky et al., 1991). And second, an inspection of the Beck Depression Inventory scores of those who completed the study (see Elkin et al., 1989) reveals that the

placebo plus clinical management condition accounted for nearly 93% of the average response to the active treatments (Duncan, 2014).

Allegiance and expectancy are two sides of the same coin—the belief by both the therapist and the client in the restorative power and credibility of the therapy's rationale and related rituals. The degree to which the therapist delivering the treatment believes the chosen therapy to be efficacious weighs in as a strong determinant of outcome in clinical trials. The therapist's allegiance to an approach contributes to the client coming to believe in a treatment as well. Expectancy and allegiance effects, therefore, are not thought to arise specifically from a given treatment procedure; they come from the hopeful expectations that accompany the use and implementation of the method.

The act of providing treatment is the vehicle that carries allegiance and placebo effects in addition to the specific effects of the given approach. It pays, therefore, to have several rationales and remedies at your disposal that you believe in, as well as believing in the client's ideas about change. Placebo factors are also fueled by a therapist belief that change occurs naturally and almost universally—the human organism, shaped by millennia of evolution and survival, tends to heal and to find a way, even out of the heart of darkness (Sparks & Duncan, 2010).

Another strength of solution focused approaches and yet another way that SFBT is congruent with common factors research is the attention given to the hope of a better future. Starting with the miracle question and a clear eye toward the future, SFBT encourages hope through compliments, presuppositional language, and ascribing any gains of therapy to client efforts and actions. Each of these behaviors inspires the expectation that change is not only possible, it is inevitable--another basic assumption and profound contribution of a solution

focused perspective.

Finally, it is important to note that suggesting specific effects are small in comparison to general effects, and that psychotherapy approaches achieve about the same results does not mean that solution focused models and techniques are not important. It only means these specific aspects of solution focused models are the vehicles that encourage *resource activation* and *client engagement*--the magnifying glass that harnesses the power of sunshine, focusing it into a single beam, and ignites change in the client's life. *SFBT happens to be in concert, in both theory and practice, with those factors that are most important to outcomes.* You may ask, then, why isn't SFBT superior to other models in direct comparisons. The reason is therapist effects. The variability among therapists impacts outcomes far more than what model the therapist is practicing. As Rosenzweig suggested, no one approach has corralled all the good therapists.

While there is no differential efficacy on aggregate, there are approaches that are likely better or worse for the client in your office now. And the only way to know that is by monitoring the outcome of your services. Before turning to the fifth common factor, a look at the state of affairs in psychotherapy will set the stage.

The Good, the Bad, and the Ugly of Psychotherapy; PCOMS to the Rescue

Necessity is the mother of invention

English Proverb

Despite overall psychotherapy efficacy (Lambert, 2013), many clients do not benefit (Reese, Duncan, Bohankse, Owen, & Minami, 2014), dropouts are a problem (Swift & Greenberg, 2012), and therapists vary significantly in success rates (Baldwin & Imel, 2013), are poor judges of negative outcomes (Chapman et al., 2012), and grossly overestimate their effectiveness (Walfish, McAlister, O'Donnell, & Lambert, 2012). Systematic client feedback

offers one solution (Duncan, 2014). It refers to the continuous monitoring of client perceptions of progress throughout therapy and a real-time comparison with an expected treatment response to gauge client progress and signal when change is not occurring as predicted. With this alert, clinicians and clients have an opportunity to shift focus, re-visit goals, or alter interventions before deterioration or dropout.

Several feedback systems have emerged (Castonguay, Barkham, Lutz, & McAleavey, 2013), but only two have randomized clinical trial (RCT) support and are included in the Substance Abuse and Mental Health Administration's (SAMHSA) National Registry of Evidence based Programs and Practices. First is the Outcome Questionnaire-45.2 System (OQ; Lambert, 2010). Michael Lambert is the pioneer of systematic feedback, evolving pre-post outcome measurement to a "real time" feedback process with a proven track record of improving outcomes. The OQ was designed to monitor client functioning at each session, the first measure to do so. Lambert and colleagues have convincingly established that measuring outcomes is not just for researchers anymore and belongs in everyday clinical practice.

The other systematic feedback intervention included in SAMHSA's National Registry is the Partners for Change Outcome Management System (PCOMS; Duncan, 2012; Duncan & Reese, 2015; Duncan & Sparks, 2018.). Emerging from clinical practice and designed with the front-line clinician in mind, PCOMS employs two, four item scales, one focusing on outcome (the Outcome Rating Scale; Miller, Duncan, Brown, Sparks, & Claud, 2003) and the other assessing the therapeutic alliance (the Session Rating Scale; Duncan et al., 2003). PCOMS directly involves clinicians and clients in an ongoing process of measuring and discussing both progress and the alliance, the first system to do so.

A meta-analytic review of six OQ System studies (*N* = 6,151) revealed clients in the feedback condition had less than half the odds of experiencing deterioration and approximately 2.6 times higher odds of attaining reliable improvement than did those in treatment as usual (TAU) (Lambert & Shimokawa, 2011). The same review evaluated three PCOMS studies (*N* = 558), and reported clients in the feedback group had 3.5 times higher odds of experiencing reliable change and less than half the chance of deterioration. This review makes a strong case for the use of systematic feedback.

There are many similarities between the two systems, and in fact, Lambert provided the inspiration for PCOMS and the OQ formed the basis of the PCOMS outcome measure, the Outcome Rating Sale (ORS). Most notably, both assess the client's response to service and feed that information back to the therapist (or to both client and clinician) to enhance the possibility of success via identification of clients at risk for a negative outcome. Both, as noted, are evidenced based practices and are a-theoretical and not diagnostically based; both systems have demonstrated significant improvements in outcomes regardless of therapist model or client diagnosis. Both have developed algorithms for expected treatment response based on extensive databases and have electronic systems for data collection, analyses, and real time feedback. Both have continued research agendas and have enjoyed widespread implementation.

But important differences exist: Unlike the OQ and most outcome instruments, the ORS is not a list of symptoms or problems checked by clients on a Likert scale. Rather it is an instrument that is individualized with each client to represent his or her idiosyncratic experience and reasons for service. Clients report their distress on three domains (personal, family, social) and the clinical conversation evolves this general framework into a specific representation of the reason(s) for service. Beyond the differences in the outcome measure, by design, PCOMS is

transparent in all aspects and intended to promote collaboration with clients in all decisions that affect their care. PCOMS is integrated into the ongoing psychotherapy process, creating space for discussion of not only progress but also the alliance (Duncan & Sparks, 2002, 2018).

The origins of the two systems are also different. While the OQ System arose from rigorous research and a desire to prevent treatment failures, PCOMS started from everyday clinical practice and a desire to privilege the client in the psychotherapy process. When feedback and the OQ were first introduced, I embraced it as a radical development—a methodology that routinely placed the client's construction of success at the center. It provided a way to operationalize what Duncan and Moynihan (1994), in an article entitled "Applying Outcome Research: Intentional Utilization of the Client's Frame Reference," called "client directed" clinical services. Applying the extensive empirical support for the common factors and especially the relationship/alliance, that article proposed a more intentional use of client "theories" to maximize common factor effects and client collaboration, and more devotion to client views of how therapy can address the reasons for service and what constitutes success.

Systematic feedback seemed not only a natural extension of this argument but, more importantly, offered a way to make it happen—a structured process to honor the client's frame of reference while encouraging clinicians to routinely and transparently discuss outcome and the alliance. Despite the OQ's obvious strengths, many clinicians complained about the length of time needed to complete the measure and that it did not seem to fit many of the concerns that clients brought to therapy. It became apparent that in spite of the quality of the measure, the benefits of outcome monitoring would not occur if therapists didn't use it. PCOMS arose from the need for a more clinician friendly measure and a desire to make manifest what mattered most in psychotherapy outcomes and a set of values about client privilege and egalitarian services.

The ORS emerged from two ideas. Arising from my roots in solution focused therapy, scaling questions quickly came to mind because they assessed client perceptions of problems and goal attainment ("On a scale of 0 to 10, with 0 being the worst it's been with this concern and 10 being where you want it to be, where are things right now?") (Berg & deShazer, 1993). Client-based scaling provides instant feedback and privileges the client's voice when assessing the effectiveness of therapy (Franklin, Corcoran, Nowicki, & Streeter, 1997). After repeated occurrences of therapist non-adherence to outcome measurement protocols I suggested to Miller that we simply ask scaling questions based on the major domains from the OQ to enable a total outcome score.

Later, after researching different formats, Miller suggested the use of a visual analog scale because of its demonstrated face validity instead of scaling questions, and the ORS (Miller & Duncan, 2000) was born. Thereafter, based in two years of private practice experience as well as the multiple teams that I supervised in the community clinic, I developed the clinical process of using the ORS and SRS and detailed it first in Duncan and Sparks (2002) and later in Duncan et al., 2004. Later, it became evident that families would be unable to participate in feedback protocols without a valid measure for children. With this as an impetus, the Child Outcome Rating Scale (CORS; Duncan, Miller, & Sparks, 2003) was developed. (All the measures discussed here are available for free download for individual use at www.betteroutcomesnow.com).

The Outcome Rating Scale (ORS)

The ORS assesses four dimensions: (1) Individual—personal or symptomatic distress or well being, (2) Interpersonal—relational distress or how well the client is getting along in intimate relationships, (3) Social—the client's view of satisfaction with work/school and

relationships outside of the home, and (4) Overall—a big picture view or general sense of well-being. The ORS translates these four dimensions into a visual analog format of four 10-cm lines, with instructions to place a mark on each line with low estimates to the left and high to the right. The four 10-cm lines add to a total score of 40. The score is the summation of the marks made by the client to the nearest millimeter on each of the four lines, measured by a centimeter ruler or web-system (www.betteroutcomesnow.com). Because of its simplicity, ORS feedback is immediately available for use at the time the service is delivered. Rated at a seventh-grade reading level and translated into multiple languages, the ORS is easily understood by adults and adolescents from a variety of different cultures and enjoys rapid connection to clients' day-to-day lived experience.

Insert Figure 2 about here

A common concern is whether such brief measures can yield reliable and valid scores. There is little doubt that information is lost when relying on only four items, but both measures hold up well to psychometric scrutiny. Multiple validation studies of the ORS (Bringhurst, Watson, Miller, & Duncan, 2006; Campbell & Hemsley, 2009; Reese, Toland, & Kodet, 2012; Miller et al., 2003) as well as efficacy studies (see below) have found that the ORS generates reliable scores. Coefficient alphas have ranged from .87 to .91 in validation studies and from .82 (Reese, Norsworthy, & Rowlands, 2009; individual therapy) to .92 (Slone, Reese, Mathews-Duvall, & Kodet, 2015; group therapy) in clinical studies.

Research also suggests that the ORS generates valid scores as a measure of general distress. Three studies found evidence of concurrent validity for the ORS by comparing ORS

scores to the OQ (Bringhurst et al., 2006; Campbell & Hemsley, 2009; Miller et al., 2003). Average bivariate correlations were .62 (range .53 - .74; Gillaspy & Murphy, 2011). Two studies have also demonstrated that scores reflect real-world treatment outcomes. Anker, Duncan, and Sparks (2009) found that couples who had higher post treatment ORS scores were more likely to be together at 6-month follow-up. Schuman, Slone, Reese, and Duncan (2015) found that active-duty soldiers who had higher post ORS scores received higher behavioral ratings from their commanders. Finally, an analysis of over 400,000 administrations of the ORS found the reliable change index (RCI) to be 6 points (Duncan, 2014) and confirmed an earlier study (Duncan, 2011) finding of a clinical cutoff (Jacobson & Truax, 1991) of 25. This RCI was recently corroborated by the Slone et al. (2015) data.

In the real world of delivering services, finding the right outcome measure means striking a balance between the competing demands of validity, reliability, and feasibility. The development of the ORS and CORS reflects an attempt to find such a balance (Duncan, 2014). Regarding SFBT, the ORS is simply a more formal and systematic way to do scaling questions.

The Session Rating Scale (SRS)

Routine assessment of the alliance enables you to identify and correct potential problems before they exert a negative effect on outcome. Moreover, continuous monitoring helps you *build* a strong alliance. Research repeatedly shows that clients' ratings of the alliance are far more predictive of improvement than the type of intervention or the therapist's ratings of the alliance. Recognizing the much replicated findings regarding the alliance as well as the need for a brief clinical tool, we developed the SRS (Miller, Duncan, & Johnson, 2002), the Child Session Rating Scale (CSRS) (Duncan, Miller, & Sparks, 2003), the Relationship Rating Scale (RRS) for peer services and self-help (Duncan & Miller, 2004), the Group Session Rating Scale (GSRS;

Duncan & Miller, 2007), and the Group Child Session Rating Sale (GCSRS; Duncan, Miller, Sparks, & Murphy, 2011) as brief alternatives to longer research-based measures to encourage routine conversations with clients about the alliance.

Insert Figure 3 about here

The SRS simply translates what is known about the alliance into four visual analog scales, based in Bordin's (1979) classic delineation of the components of the alliance: the relational bond and the degree of agreement between the client and therapist about the goals and tasks of therapy. First, a relationship scale rates the meeting on a continuum from "I did not feel heard, understood, and respected" to "I felt heard, understood, and respected." Second is a goals and topics scale that rates the conversation on a continuum from "We did not work on or talk about what I wanted to work on or talk about" to "We worked on or talked about what I wanted to work on or talk about." Third is an approach or method scale requiring the client to rate the meeting on a continuum from "The approach is not a good fit for me" to "The approach is a good fit for me." Finally, the fourth scale looks at how the client perceives the encounter in total along the continuum: "There was something missing in the session today" to "Overall, today's session was right for me." Like the ORS, the instrument takes only a couple of minutes to administer, score, and discuss. The SRS is scored similarly to the ORS, by adding the total of the client's marks on the four 10-cm lines. The SRS is based on encouraging clients to identify alliance problems, to elicit client disagreements about the therapeutic process so that the clinician may change to better fit client expectations.

The SRS also has evidence of generating reliable and valid scores. Gillaspy and Murphy (2011) reported the average internal consistency of SRS scores across five studies equaled .92 (range .88 to .96). SRS scores also exhibit moderate evidence for concurrent validity with longer alliance measures; $r = .48$ with the Helping Alliance Questionnaire-II (Duncan et al., 2003), $r = .63$ with the Working Alliance Inventory (Campbell & Hemsley, 2009), and $r = .65$ with the Working Alliance Inventory – Short Revised (Reese et al., 2013). The predictive validity of SRS scores has been supported by two studies. Duncan et al. (2003) found a correlation of $r = .29$ between early SRS scores and outcome, which is consistent with previous alliance-outcome research (Horvath, Del Re, Flückiger, & Symonds, 2011). More recently, Anker et al. (2010) reported third session SRS scores predicted outcome beyond early symptom change ($d = 0.25$). Regarding the cutoff score for the SRS, a conservative estimate derived for clinical purposes with descriptive statistics (score at which the majority of clients are above) from the original analysis (Miller & Duncan, 2004) and updated from Anker et al. (2010) is 36.

A second concern raised regarding the validity of the measures is whether clients are unduly influenced by the PCOMS protocol of discussing the scores, particularly for the SRS. Reese et al. (2013) focused on social desirability and demand characteristics of completing the SRS in the presence of a clinician and did not find differences when clients were randomized to conditions where they completed the measure in front of their therapist, in private, or anonymously—clients completed the SRS similarly regardless of the demand characteristics and social desirability was not a factor.

PCOMS: The Research

However beautiful the strategy, you should occasionally look at the results.

Sir Winston Churchill

There are currently six randomized clinical trials (RCT) that support the efficacy of PCOMS in individual (Reese et al., 2009; She et al., 2018), couple (Anker et al., 2009; Reese et al., 2010), and group (Schuman et al., 2015; Slone et al., 2015) therapy with adults, with overall effect sizes ranging from d = 0.28 (group therapy) to 0.54 (individual therapy). Reese et al. (2009) conducted two studies where individual clients were randomized to a PCOMS or TAU condition. In both studies, clients in the feedback condition demonstrated roughly twice as much improvement on the ORS compared to TAU clients. In addition, more feedback clients achieved reliable change in significantly fewer sessions than TAU clients. Comparable ESs were found in each study.

Anker et al. (2009) randomized 205 couples to feedback or TAU. Compared to couples who received TAU, twice as much improvement was found on the ORS for feedback clients (8.27 vs. 3.11 points). Nearly four times as many couples in the feedback condition reached clinically significant change. These effects were maintained at 6-month follow-up and those in the feedback condition were significantly more likely to be together. Reese et al. (2010) replicated these findings in a second couple study (N = 92) in terms of ORS gains (8.58 vs. 3.64 points) and clinically significant change. PCOMS clients also improved at a faster rate.

More recently, PCOMS research has extended to group psychotherapy with two RCTs. Schuman et al. (2015) evaluated an abbreviated PCOMS intervention with active Army soldiers in substance abuse treatment. Therapists in the abbreviated PCOMS format only received a graph based on ORS scores for each session indicating whether their group participants were progressing as expected. Therapists were not required to discuss the ORS nor did clients utilize the Group Session Rating Scale (GSRS; Duncan & Miller, 2007). Also, only the first five sessions of treatment were evaluated. Even with these limitations, participants in the PCOMS

condition had larger pre-post treatment gains and attended more sessions compared to TAU clients. Clients in the PCOMS condition also received higher blinded ratings from their commanding officers. A second group psychotherapy study (Slone et al., 2015) conducted in a university counseling center found PCOMS clients had significantly larger pre-post treatment gains and higher rates of reliable and clinically significant change when compared to TAU clients. Therapists had access to both ORS and GSRS scores and were encouraged to discuss the measures with clients during group sessions.

Finally, a sixth RCT conducted in China unequivocally proves that PCOMS is not just a Western phenomenon. She et al. (2018) found a six times more reliable change advantage for the PCOMS condition. Taken together, these six RCTs demonstrate a significant advantage of PCOMS over TAU. Clients in feedback conditions achieved more pre-post treatment gains, higher percentages of reliable and clinically significant change, faster rates of change, and were less likely to drop out. These findings suggest that systematic feedback could offer a more cost effective and practical alternative as a quality improvement strategy compared to the transporting of evidence based treatments. To evaluate PCOMS as a quality improvement strategy, Reese et al. (2014) employed benchmarking to investigate the post-treatment outcomes of 5,168 racially diverse, impoverished (all below the federal poverty level) adults who received therapy in a public behavioral health setting. The overall treatment effect size ($d = 1.34$) for those with a depressive disorder ($N = 1{,}589$) was comparable to treatment efficacy benchmarks from clinical trials of major depression ($d = 0.89$). Treatment effect sizes for the entire sample ($d = 0.71$) were also comparable to benchmarks derived from nine client feedback RCT studies ($d = 0.56$) that used the OQ System and PCOMS (Lambert & Shimokawa, 2011).

PCOMS individualizes psychotherapy based on treatment response, provides an early warning system that identifies at risk clients thereby preventing drop-outs and negative outcomes, and suggests a tried and true solution to the problem of therapist variability—namely that feedback necessarily improves performance. Think of that advantage in your practice. Consider the pool of clients in your practice right now who are not benefiting. PCOMS could allow you to recapture good outcomes with many of those clients who would otherwise not benefit.

An inspection of Figure 1 shows that feedback overlaps and affects all the factors—it is the tie that binds them together—allowing the other common factors to be delivered one client at a time. Soliciting systematic feedback is a living, ongoing process that engages clients in the collaborative monitoring of outcome, heightens hope for improvement, fits client preferences, maximizes therapist-client alliance potential and client participation, and is itself a core feature of therapeutic change. Feedback embodies the lessons I learned from Tina, providing for a transparent interpersonal process that solicits the client's help in ensuring a positive outcome.

SFBT is strongly behind the belief that clients are better positioned than anyone else to inform and evaluate the therapy process in ways that are most beneficial to them--the client is the ultimate authority on the usefulness of services. PCOMS merely incorporates this belief in a more formal way to provide immediate feedback on what is working and what is not

The Clinical Process[2]

The only man I know who behaves sensibly is my tailor; he takes my measurements anew each time he sees me. The rest go on with their old measurements and expect me to fit them.

George Bernard Shaw

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[1] The PCOMS family of instruments in 28 languages are free for individual use at betteroutcomesnow.com

PCOMS is a-theoretical and may be added to or integrated with any model of practice, but it fits particularly well with SFCT. The Partners for Change Outcome Management System provides a methodology to partner with clients to identify those who aren't responding and address the lack of progress in a proactive way that keeps clients engaged while new directions are collaboratively sought. PCOMS is a light-touch, checking-in process that usually takes about 5 minutes to administer, score, and integrate into the psychotherapy. Besides the brevity of its measures and therefore its feasibility for everyday use in the demanding schedules of clinicians, PCOMS is distinguished by its routine involvement of clients; client scores on the progress and alliance instruments are openly shared and discussed at each administration. Client views of progress serve as a basis for beginning conversations, and their assessments of the alliance mark an endpoint to the same. With this transparency, the measures provide a mutually understood reference point for reasons for seeking service, progress, and engagement. PCOMS is used in mental health and substance abuse settings across the United States, Canada, and over 20 other countries, with over 1.5 million administrations in its database.

PCOMS and the session start with the Outcome Rating Scale. Clients place a mark (or mouse click or touch) on each line to represent their perception of their functioning in each domain. Therapists use a 10 cm ruler (or betteroutcomesnow.com) to sum the client's total score, with a maximum score of 40. Lower scores reflect more distress.

Introducing the ORS includes two points: 1) the ORS is a way to make sure that the client's voice remains central; and 2) the ORS will be used to track outcome in every session.

> *I like to start with this brief form called the Outcome Rating Scale, which provides a snapshot of how you are doing right now. It serves as an anchor point so we can track your progress and make sure that you get what you came here to get, and if you're not,*

we can regroup and try something else. It's also a way to make sure that your perspective of how you are doing stays central. Would you mind doing it for me (handing the client the iPAD)?

The task after the score is totaled is to make sense of it with the final authority—the client. The "clinical cutoff" facilitates a shared understanding of the ORS and is often a step toward connecting client marks on the ORS to the reason for services.

Therapist: This measure, the ORS, based on where you touched the line, gives a score from 0 to 40 and then your score is plotted on this graph. So let's see if you think this accurately describes how things are going for you. You scored a 16.3. See this line, here, the line between the pink or mauve and the green, that is the score that tends to separate people who are seeking services from those who are not. People who score under 25 tend to be those who wind up talking to people like me, they're looking for something different in their lives. You scored about the average intake score of persons who enter therapy, so you're in the right place. And it's not hard to look at this and see pretty quickly that it's the family/close relationship area you are struggling with the most right now. Does that make sense?

Client: Yes, definitely.

Therapist: And this green line here, that's what we are hoping will happen if our work together is successful. So what do you think would be the most useful thing for us to talk about? You can start with that lowest scale or start wherever you want.

Client: Well, I am in the middle of divorce and struggling with figuring this out…

Clients most often mark the scale the lowest that they are there to talk about. The ORS brings an understanding of the client's experience to the opening minutes of a session.

Insert Figure 4 about here

The ORS is individually tailored by design, requiring the practitioner to ensure that the ORS represents both the client's experience and the reasons for service. At the moment clients connect the marks on the ORS with the situations that prompt their seeking help, the ORS becomes a meaningful measure of progress and a potent clinical tool—leading to the next question: "What do you think it will take to move your mark just one cm to the right; what needs to happen out there and in here?" With the same client as above:

> *Therapist: If I am getting this right, you said that you are struggling with the divorce, specifically about why it happened and your part in it so you are looking to explore this and gain some insight into what perhaps was your contribution. You marked the Interpersonally Scale the lowest* (Therapist picks up the iPAD and points to the mark on the Interpersonal line.) *Does that mark represent this struggle and your longing for some clarity?*
>
> *Client: Yes.*
>
> *Therapist: So, what do you think it will take to move your mark just 1 cm to the right? What do you think you would notice in your life that would lead to a slightly higher score? And what do we need to do in here to support that happening?*

The ORS sets the stage and focuses the work at hand.

The Session Rating Scale (SRS) is given toward the end of a session. Similar to the ORS, each line on the SRS is 10 cm and can be scored manually or electronically. Use of the SRS encourages all client feedback, positive and negative, creating a safe space for clients to voice

their honest opinions about their connection to their therapist and to psychotherapy. Introducing the SRS works best as a natural extension of the therapist's style:

> *Let's take a minute and have you fill out the other form about our work together, the Session Rating Scale. It's kind of like taking the temperature of our session today. Was it too hot or too cold? Do I need to adjust the thermostat to make you feel more comfortable? The purpose is to make every possible effort to make our work together beneficial for you. If something is amiss, you would be doing me the best favor to let me know because then I can do something about it. Would you mind doing this for me?*

For clients scoring above the cutoff of 36, the therapist need only thank the client, inquire about what the client found particularly helpful, and invite the client to please inform the therapist if anything can improve the therapy. For clients scoring below 36, the conversation is similar but also attempts to explore what can be done to improve the therapy. The SRS provides a structure to address the alliance, allows an opportunity to fix any problems, and demonstrates that the therapist does more than give lip service to forming good relationships.

After the first session, PCOMS simply asks: are things better or not? ORS scores are used to engage the client in a discussion about progress, and more importantly, what should be done differently if there isn't any. When ORS scores increase, a crucial step, in true solution focused form, is to empower the change and help clients see any gains as a consequence of their own efforts. Reliable and clinically significant change as well as meeting the expected treatment response provide helpful metrics to gauge noted gains. When clients reach a plateau or what may be the maximum benefit they will derive from service, planning for continued recovery outside of therapy starts.

A more important discussion occurs when ORS scores are not increasing. The longer psychotherapy continues without measurable change, the greater the likelihood of dropout and/or poor outcome. PCOMS is intended to stimulate both interested parties to reflect on the implications of continuing a process that is yielding little or no benefit. Although addressed in each meeting in which it is apparent no change is occurring, later sessions gain increasing significance and warrant additional action—what we have called *checkpoint conversations* and *last chance discussions* (Duncan & Sparks, 2002; Duncan & Sparks, 2018).

Checkpoint conversations are conducted at the third to sixth session and last-chance discussions are initiated in the sixth to ninth meeting. The trajectories observed in outpatient settings suggest that most clients who benefit usually show it in 3–6 sessions (Duncan, 2014); and if change is not noted by then, then the client is at a risk for a negative outcome. The same goes for sessions 6-9 except that the urgency is increased, hence the term “last chance.” Better Outcomes Now provides a more nuanced identification of clients at risk by comparing the client’s progress to the expected treatment response of clients with the same intake score (see Figure 4). It graphs and compares the client’s progress to the expected treatment response of clients with the same intake score (the 50th percentile trajectory based on 400, 000 administrations of the ORS), allowing an ongoing comparison and discussion with the client.

The progression of the conversation with clients who are not benefiting goes from talking about whether something different should be done, to identifying what can be done differently, to considering other treatment options including transferring the client to a different provider. The conversation begins:

> *Okay, so things haven’t changed since the last time we talked. How do you make sense of that? Should we be doing something different here, or should we continue on course*

steady as we go? If we are going to stay on the same course, how long should we go before getting worried? When will we know when to say "when?

PCOMS spotlights the lack of change, making it impossible to ignore, and often ignites both therapist and client into action—to consider other options and evaluate whether another provider may offer a different set of options and perhaps a better match with client preferences, culture, and frame of reference.

Implementing PCOMS

Successful implementation of PCOMS requires data collection, data integrity, and the timely dissemination of data to both clinicians and supervisors. A four step supervisory process (Duncan & Reese, 2015b; Duncan & Sparks, 2018) focuses first on ORS identified clients at risk and then on therapist development. PCOMS shifts the conversation in supervision away from our love affair with models and preoccupation with psychopathology. Based on outcome data instead of theoretical explanations or pontifications about why clients are not changing, supervision is aimed at identifying clients who are not benefiting so that services can be modified in the *next* session.

This supervision is a departure from convention because rather than the supervisee choosing who is discussed, clients choose themselves by virtue of their ORS scores and lack of change. Each at risk client is discussed and options are developed to present to clients, including the possibility of consultation with or referral to another counselor or service. This is perhaps the most traditional role of supervision but here there are objective criteria to identify at risk clients as well as subsequent ORS scores to see if the changes recommended by the supervisory process have been helpful to the client. This process is intended to be the antidote for blaming clients or therapists. Not all clients benefit from services. No clinician serves all clients. If we accept that,

we can move on to the more productive conversation of what needs to happen next to enable the consumer to benefit.

PCOMS supervision is about improving outcomes via the identification of at risk clients first and foremost, and then focuses on the supervisee and professional development using ORS data as an objective standard of effectiveness over time. PCOMS not only privileges the client in therapy, it carries a consumer first priority into the supervisory process, and ultimately to the way that effectiveness at all levels of service are evaluated.

PCOMS and Better Outcomes Now

Until lions have their historians, tales of hunting will always glorify the hunter.

African Proverb

There are six rationales for PCOMS. First, PCOMS is supported by six RCTS demonstrating that client outcome and alliance feedback significantly improves outcomes in individual, couple, and group therapy. Second, PCOMS has demonstrated that it is a viable quality improvement strategy in real world settings and may be more cost effective and feasible that transporting evidence based treatments for specific disorders (Reese et al., 2014). Third, PCOMS reduces dropouts, cancelations, no shows, and length of stay (Bohanske & Franczak, 2010), provides objective information about clinician effectiveness, and reduces therapist variability (Anker et al., 2009). Fourth, PCOMS incorporates two known predictors of ultimate treatment outcome, early change (Howard et al., 1986; Baldwin, Berkeljon, Atkins, Olsen, & Nielsen, 2009), and the therapeutic alliance (Horvath et al., 2011). Monitoring change and the alliance provides a tangible way to identify non-responding clients and relationship problems before clients drop out or achieve a negative outcome. Fifth, PCOMS directly applies the research about what really matters in therapeutic change, the common factors (Duncan et al.,

2010). Collaborative monitoring of outcome engages the most potent source of change, clients (Bohart & Tallman, 2010), thereby heightening hope for improvement, and tailors services to client preferences thereby maximizing the alliance and participation (Duncan, 2014).

Finally, a sixth rationale started long before the psychometrics, RCTs, or benchmarking studies. Routinely requesting, documenting, and responding to client feedback has the potential to transform power relations by privileging client beliefs and goals over potentially culturally biased and insensitive practices. Valuing clients as credible sources of their own experiences of progress and relationship allows consumers to teach us how we can be the most effective with them and reverse the hierarchy of expert delivered services. PCOMS provides a ready-made structure for collaboration with consumers and promotes a more egalitarian psychotherapeutic process. It ensures therapy's match with a client's preferred future via monitoring progress on the ORS. And it provides a way to calibrate therapy to a client's goals and preferred way of achieving goals via monitoring the alliance with the SRS. Thus, PCOMS promotes the values of social justice by privileging consumer voice over manuals and theories enabling idiosyncratic and culturally responsive practice with diverse clientele. Given that clients are the lions of change, PCOMS intends for them to be the historians of their own change.

Better Outcomes Now (BON; https://betteroutcomesnow.com) is a practice-driven research and training initiative focusing on improving outcomes via PCOMS. We are committed to consumer privilege, a relational model of psychotherapy, outcome accountability, and demonstrating that social justice makes empirical sense. BON is responsible for PCOMS scientific credibility and is dedicated to consumer privilege and social justice. These important distinctions lead to a more informed approach to PCOMS training. The website is a major

dissemination vehicle with over 250 free downloads (articles, handouts, slides, videos, and webinars) related to PCOMS and the common factors.

Staying with What Works: One Client at a Time

At bottom every man (sic) knows well enough that he is a unique being, only once on this earth; and by no extraordinary chance will such a marvelously picturesque piece of diversity in unity as he is, ever be put together a second time.

Friedrich Nietzsche

Psychotherapy is not an uninhabited landscape of technical procedures. It is not the sterile, stepwise, process of surgery, nor does it follow the predictable path of diagnosis, prescription, and cure. It cannot be described without the client and therapist, co-adventurers in a journey across what is largely uncharted territory. The common factors provide useful directions for this intensely interpersonal and idiosyncratic trip, and specific models and techniques provide well-traveled routes to consider, but PCOMS offers a necessary compass to provide bearings of the psychotherapy terrain and guidance to the client's desired destination.

Solution focused approaches can only be praised for their enormous contributions to all therapies. The significance of removing psychotherapy's pathology blinders can hardly be overstated. SFBT's interest in client resources and client goals proved remarkably on track with the most robust finding in outcome research—that client contributions and attending to client preferences and goals accounts for the lion shares of outcome in therapy. Solution focused pioneer Steve de Shazer introduced the radical notion that the solution need have no relationship to the problem, running directly counter to the medical model's insistence that a discrete, diagnosed disorder then dictates a specific, matched intervention. At the same time, an understanding of solutions as non-problem specific frees therapists and clients to travel multiple

paths in a more client directed and creative search for problem resolution. In addition, SFBT's attention to the future provides a natural enhancement of hope and expectancy factors replacing the dismal past with a possibility-filled future. Finally, solution focused therapy's roots in Ericksonian ideas keeps the client's worldview center stage as well in an interest in learning and validating the client's theory of change as a critical component of strengthening the therapeutic alliance and enhancing positive outcome. Solution focused models were prescient applications of what was later confirmed by the bulk of outcome research.

Similar to the other common factors, monitoring client feedback via the PCOMS is a natural fit with solution focused clinical work, a mere extension of the practice of scaling. SFBT partnerships are founded on the belief that clients are better positioned than anyone else to know what is best for them as well as what works best for them. In addition, solution focused approaches have a legacy of giving utmost attention to what works so both the client and therapist can do more of it. It also strongly believes in the MRI idea--if it doesn't work, do something different. PCOMS provides immediate feedback on what is working and what is not, only cementing a relationship between itself, the common factors and SFBT, a ménage a trois made in heaven.

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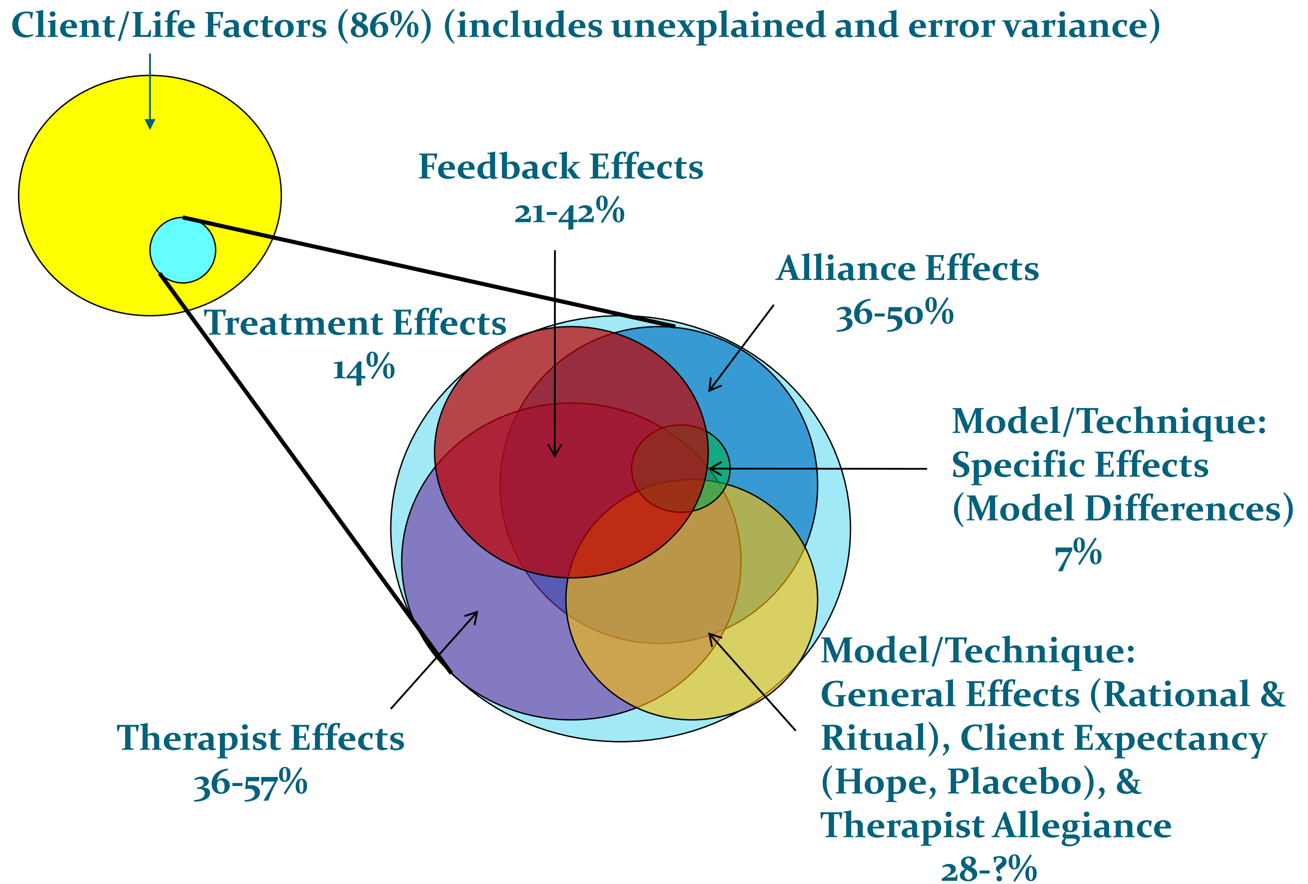
Figure 1. The Common Factors



Note: Adapted from: Duncan, B.L. (2014). *On becoming a better therapist: Evidence based practice one client at a time,* 2nd ed. Washington, D.C.: American Psychological Association.

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Outcome Rating Scale (ORS)

Name ________________________Age (Yrs.): ___ Gender: ___________
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, including today, help us understand how you have been feeling by rating how well 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

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____
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Figure 3. The Session Rating Scale. Copyright Barry L. Duncan and Scott D. Miller. For examination only. Download free working copies at https://www.betteroutcomesnow.com. Many translations are available. Electronic version at www.betteroutcomesnow.com.

Session Rating Scale (SRS V.3.1)

Name ____________________ Age (Yrs.): ____
ID# _____________________ Gender: _____
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

____________ approach is *not* a good fit for me. I---I ____________ 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.

Better Outcomes Now

https://betteroutcomesnow.com

Figure 4. Graph page of Better Outcomes Now depicting client score relative to clinical cutoff and the expected treatment response. See www.betteroutcomesnow.com.