Psychotherapy

ISSN: 0033-3204

https://doi.org/10.1037/pst0000524

The Evolution of Feedback: Toward a Multicultural Orientation

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There have been great strides in psychology regarding diversity, equity, inclusion, and multicultural competence, but a need remains to translate these values into actionable practices in psychotherapy. While the case has been made that measurement-based care is an evidence-based intervention that improves outcomes and reduces dropouts (de Jong et al., 2021) and recently that it provides a transparent collaborative process to engage clients in treatment (Boswell et al., 2023), it has not been widely considered as a methodology for multicultural competence. We trace the evolution of what was once called "patient-focused research" (Lambert, 2001) and identify a significant change in recent writings to include important clinical and collaborative processes, a transition from a strictly normative or nomothetic understanding of the value of feedback to an appreciation of its communicative or idiographic processes. We propose that systematic client feedback promotes a "multicultural orientation" (Owen, 2013) at the individual therapist–client level and that client responses to outcome and process measures can foster cultural humility and create cultural opportunities (Hook et al., 2017) to address marginalization and other sociocultural factors relevant to treatment. Using one system to illustrate what is possible for all feedback approaches, we present client examples that demonstrate an integration of a multicultural orientation. We suggest that systematic client feedback can provide a structure to address diversity, marginalization, and privilege in psychotherapy.

Clinical Impact Statement

Question: Can measurement-based care (MBC) continue its evolution to collaborative, transparent processes and provide a methodology for multicultural competence? ***Findings:*** Recent accounts of MBC have highlighted important clinical and collaborative practices, a transition from a strictly normative understanding of the value of feedback to an appreciation of its communicative processes. ***Meaning:*** MBC enables a structure to translate multicultural guidelines into actionable therapist behaviors to address diversity, marginalization, and clinician-client differences. ***Next Steps:*** While one MBC system with a heritage of client privilege and social justice was offerred as an illustration of a multicultural orientation (Owen, 2013), other client feedback systems can similarly begin to contextualize their outcome measures beyond symptoms to address oppression as well as include alliance measures to encourage discussion of therapist-client differences.

Keywords: multicultural competence, multicultural orientation, measurement-based care, systematic client feedback, routine outcome monitoring

Several terms describe the use of outcome and/or process measures to track client progress and inform intervention across the course of treatment. Regardless of terms, only two have extensive randomized clinical trial (RCT) support: the Outcome Questionnaire −45 System (Lambert, 2015; Lambert et al., 2001) and the Partners for Change Outcome Management System (PCOMS; Anker et al., 2009; Duncan & Reese, 2015). These two systems account for 74% of the recent de Jong et al.'s (2021) meta-analysis. de Jong et al. reported a small yet statistically significant effect of progress feedback on symptom reduction ($d = 0.15$), as well as a favorable effect on dropout rates ($OR = 1.19$).

While empirical demonstrations of improved outcomes and reduced dropouts continue and the accompanying clinical processes are increasingly understood as critical (Boswell et al., 2023), an important component has yet to be explored, namely how client feedback can promote a multicultural orientation (MCO; Owen, 2013). Building on a multicultural competence model, Davis et al. (2018) described MCO as "… concerned with how the cultural

The authors dedicate this article to their dear friend and colleague, Jacqueline A. Sparks, whose lifetime passion for and commitment to client privilege, cultural responsiveness, and social justice is embedded in every page and sorely missed.

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Barry L. Duncan played a lead role in conceptualization and writing–review and editing. Robert J. Reese played a supporting role in conceptualization and writing–review and editing.

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worldviews, values, and beliefs of the client and the therapist interact and influence one another to cocreate a relational experience that is in the spirit of healing" (p. 90).

Further clinical application of MCO seems imperative given that research consistently shows that therapists differ in their effectiveness with clients from historically oppressed groups (Anderson et al., 2019; Soto et al., 2018). To help address these disparities, the American Psychological Association (APA) (2018) has adopted multicultural guidelines, and training programs now place more emphasis on sociocultural context in assessment and treatment. Celebrating diversity, equity, and inclusiveness, as well as striving for multicultural competence, are firmly embedded in psychology's ethics codes, graduate training, and professional ethos.

A challenge remains, however, in how to translate these values, ethics, and guidelines into actionable behaviors for clinicians (Davis et al., 2018). This article proposes that client feedback can provide a communicative process that promotes cultural humility, creates opportunities for cultural exploration, and enhances therapist cultural comfort—the three pillars of MCO (Hook et al., 2017)—to address marginalization and therapist–client differences. We trace the evolution of measurement-based care (MBC) and identify a significant change in recent writings to include collaborative processes, a transition from a strictly normative or nomothetic understanding of feedback to an appreciation of its communicative or idiographic processes (Duncan & Reese, 2013). Using one feedback system to illustrate what is possible for all MBC approaches, we exemplify how client feedback can provide a methodology for integrating MCO.

Evolution of Feedback

The field has come a long way since the original conceptualizations of feedback by pioneers Michael Lambert and Kenneth Howard (Howard et al., 1996; Lambert et al., 1996). In 2001, the year of the first feedback RCT (Lambert et al., 2001), in a special issue of the *Journal of Consulting and Clinical Psychology*, Lambert described patient-focused research:

> Endeavors to improve psychotherapeutic outcome by monitoring patient progress and using this information to guide ongoing treatment … patient-focused research attempts to answer the question, Is this particular treatment working for this patient? (pp. 147–148)

Thus, if an at-risk client can be reliably identified before dropping out or deteriorating, then therapists will have an opportunity to modify treatment accordingly.

Fast forward to a 2023 special feature of the journal *Psychotherapy*. Boswell et al. (2023) proposed MBC as a professional practice guideline, partially based on MBC's "fundamental provision of feedback and empowering patient engagement …" (p. 3).

> Consistent with calls to deliver person-centered, transparent, and collaborative care that empowers patients to be active participants in shaping their treatment … , MBC allows for treatment to be tailored to the individual patient according to their specific needs. It also provides a structure that facilitates exchange of information and supports shared decision-making about treatment goals and course of care. (pp. 6–7)

This attention paid to collaborative clinical processes and shared decision making is also highlighted in other recent MBC articles (Barkham et al., 2023; Barber & Resnick, 2023).

Illustrating the evolution of thought regarding feedback, compare the recent trend to the 2015 *Psychotherapy* special issue on "Progress Monitoring and Feedback." Although instructions to the authors requested discussion of clinical application of their systems, only one, PCOMS, provided detail about accompanying collaborative processes (Reese et al., 2024). The included approaches conceptualized feedback as mainly a normative or nomothetic endeavor, while PCOMS included communicative or idiographic components.

Collaborative clinical processes have been a part of PCOMS since its beginning (Duncan & Sparks, 2002). In the special *Psychotherapy* issue, Duncan and Reese (2015) suggested:

> 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 … with this transparency, the measures provide a mutually understood reference point for reasons for seeking service, progress, and engagement. (p. 347)

MBC approaches largely arose from psychometric research and a desire to prevent treatment failure. In contrast, PCOMS (Duncan & Sparks, 2002) emerged from everyday practice and an aspiration to privilege the client in the psychotherapy process (Duncan & Moynihan, 1994).

Partners for Change Outcome Management System

Concerns regarding the feasibility of the 45-item Outcome Questionnaire and a desire to honor client privilege and apply the common factors (Duncan & Moynihan, 1994) provided the impetus for the Outcome Rating Scale (ORS; Miller & Duncan, 2000) and the Session Rating Scale V.3 (SRS; Miller et al., 2002). The clinical process of PCOMS was developed from Duncan's clinical practice and supervision of graduate students in a multicultural clinic and detailed in the first PCOMS manual (B. Duncan & Sparks, 2002; now in its fourth edition). Over time, psychometric studies were published (Duncan et al., 2003; Miller et al., 2003), and Duncan et al. completed eight RCTs (Anker et al., 2009; Cooper et al., 2021; Duncan et al., 2021; Reese et al., 2009, 2010; Schuman et al., 2015; She et al., 2018; Slone et al., 2015). PCOMS, while starting as a purely clinical process, evolved to be both a normative and communicative system (Sparks & Duncan, 2018) or both nomothetic and idiographic. The feedback field, in general, started as a nomothetic process and has evolved to be both normative and communicative.

PCOMS and a Multicultural Orientation

Consider again the evolution of the feedback literature. In that 2015 *Psychotherapy* special issue, none of the approaches, except PCOMS, discuss multicultural competence or social justice beyond providing data to examine differential effectiveness (Reese et al., 2024). An examination of Barber and Resnick (2023), Barkham et al. (2023), and Boswell et al. (2023), however, reveals an emphasis on cultural sensitivity and adaptation of the measures, content, and processes of MBC to benefit diverse populations, as recommended by the APA multicultural guidelines. While an important step forward and an example of the evolution of the field, the specifics of how adaptation of MBC can occur are yet to be explored. Notably, Barber and Resnick (2023) suggested that MBC has "the potential to

reduce disparities for underserved groups because MBC increases transparent collaboration and communication and improves outcomes, and therefore may increase trust in minority populations" (p. 7). We concur and have observed this potential realized in our practices of PCOMS (Duncan, 2014).

Attention to individual experience, "amplifying client voice," and "socially just practice" (Duncan & Sparks, 2002, p. iii) have been part of PCOMS since the beginning, but more fully articulated in later publications. For example, Duncan (2012) asserted:

> PCOMS seeks to level the psychotherapy process by inviting collaborative decision making, honoring client diversity with multiple language availability, and valuing local cultural and contextual knowledge; PCOMS provides a mechanism for routine attention to multiculturalism and social justice. (pp. 98–99)

Valuing clients as credible sources of their own experiences, a central PCOMS value, is a necessary precursor to multicultural competence (Sue et al., 2022), enabling therapists to critically examine assumptions and practices and allow clients to teach clinicians how to be most effective with them (Duncan & Reese, 2015). This potential of PCOMS to promote cultural humility and create cultural opportunities has been recognized in graduate training in both marriage and family (Sparks et al., 2011) and counseling psychology (Minieri et al., 2015) programs.

We believe that the clinical process of PCOMS is congruent with cultural humility (Hook et al., 2017) because it continually engages the client's perspective and intentionally gives space for their preferences, values, and cultural beliefs in relation to their reasons for service and the therapeutic relationship itself. PCOMS promotes a therapeutic stance of curiosity about the entire person and models humility by embracing feedback about how the therapist can make the process more meaningful. Such a stance helps build an overall comfort in the room regarding differing perspectives, including cultural differences. Consistent with Davis et al. (2018), we believe that PCOMS can facilitate MCO because it offers a stance of "how to be" rather than what to do with clients. This is also congruent with one of the underlying rationales of PCOMS, that is, it is rooted in an understanding that no one approach works for everyone and that no one approach is superior (Duncan et al., 2010; Duncan & Moynihan, 1994). It is in the building of relationship with clients and being responsive to their needs that collaboratively determine the best way forward with that client—a way that is culturally responsive to their unique and intersecting identities, values, and beliefs. This aligns with the three pillars of MCO: cultural humility, cultural opportunities, and cultural comfort (Davis et al., 2018).

Cultural humility consists of five dimensions: "(a) lifelong motivation to learn from others, (b) critical self-examination of cultural awareness, (c) interpersonal respect, (d) developing mutual partnerships that address power imbalances, and (e) an other-oriented stance open to new cultural information" (Mosher et al., 2017, p. 223). Cultural opportunities are defined as points within a therapy session where a client's values, beliefs, or other characteristics of their culture and cultural identity can be addressed (Owen et al., 2016). Seeking and listening for cultural opportunities is a means of putting cultural humility into action. Cultural comfort refers to the therapist's level of ease, openness, or willingness to discuss issues of culture with clients (Owen et al., 2017). PCOMS illustrates how all feedback systems can incorporate MCO.

Toward a Multicultural Orientation: Clinical Examples Using MBC

PCOMS employs two four-item scales, one focusing on outcome, the ORS (Miller et al., 2003), and the other on the therapeutic alliance, the SRS (Duncan et al., 2003). PCOMS directly involves clinicians and clients in an ongoing collaborative process of measuring and discussing both progress and the alliance, the first system to do so (Duncan & Reese, 2015). The ORS enables exploration of the systemic impacts on individual distress, like oppression and discrimination, while the SRS promotes discussion of how client and therapist social locations may influence their work together.

The Outcome Rating Scale

The ORS is a visual analogue instrument that is individualized with clients to represent their distress and the reasons for service on four domains (personal, interpersonal, social, overall). Clients place a mark on each 10-cm line to represent their functioning in each domain or a tap on an electronic device. A centimeter ruler is used to measure the distance to the millimeter from the left end of the scale to the client's mark on each line, or it is scored by a web application. Scores range from 0 to 40, with lower scores signaling higher distress.

The major domains of life depicted on the ORS offer a general framework of human existence to which clients add the intimate details of their lived experience via therapeutic conversation. The ORS contextualizes presenting problems beyond diagnostic categories, running counter to practices that pathologize clients of color and other historically marginalized groups at higher rates (Sue et al., 2022). Putting client reasons for service in context also promotes consciousness raising for both client and therapist, helping to identify forms of oppression and marginalization that may contribute to distress.

Clinical Process of the ORS

Inquiring about and honoring client perspectives on outcome starts with a shared understanding of the purpose of therapy. Clients rate themselves, resulting in a score that only they can interpret. The therapist provides reference points (clinical cutoff, expected treatment response [ETR]) gleaned from normative data to understand the client's score and validate their experience (e.g., "People who score this low tend to be having a rough time of it, is that right?" Or "You scored like people who are looking for a change, is that right?"), but the client is the final arbiter of meaning. The content-free dimensions of the ORS allow clients to describe the meaning of their scores without preconceived theory, symptom, or therapist-derived constraints. Thus, client accounts retain the richness of real life, including the unique backstories that contextualize their dilemmas, including the possibility of oppression and discrimination.

Client 1, the ORS. The client[1] is a 32-year-old cisgender woman, a recent immigrant from Mexico. The therapist, a 45-year-old cisgender Cuban American woman, introduces the ORS and explains the rationale for doing it, a key component of engaging clients in a collaborative, transparent psychotherapy. The therapist

[1] Composites of actual clients with some demographics and other information altered to protect confidentiality.

asked the client if she preferred to conduct the session in Spanish, but she declined, saying she needed to practice her English. She did, however, prefer the ORS in Spanish.

Therapist: *This Outcome Rating Scale is used for two reasons: The main reason is to ensure that your viewpoint about things stays central to the way the work is done, your viewpoint about whether you are benefiting essentially will drive the therapy. The other reason is that if we monitor your benefit together every time you come in and you are not doing well, we can put our heads together and figure out something else to do (Hands client the ORS in Spanish on an iPad). Put a touch where you see yourself in these major areas of your life where this side means things are going very well and this side means things are going not so well (Client fills out the ORS and hands the iPad back to therapist).*

The therapist notes the client's score and suggests what it might mean using the clinical cutoff as a reference point, and then looks for client feedback to see if it is an accurate depiction of the client's experience. Figure 1 displays the score and provides the reference point via different colors that depict under versus over the clinical cutoff. Finally, the ETR is explained to continue total transparency. The introduction of the ORS already demonstrates a dimension of cultural humility, overtly noting the desire to keep the client's perspective central to the process.

Therapist: *Okay, you scored a 14.7 (Therapist and client look at graph.) People tend to score in the mauve part of this graph (under 25) when they are looking for a change in their life, when they are looking for something different. And you are scoring like a person who is having a really hard time of it, a lot of distress in your life. Does that fit you? (Client whispers "Yes."). People scoring in the green (over 25) tend to be people who don't end up talking to people like me (Client looking at graph). This bold green line (the ETR) is what we are hoping will happen for you if our work is successful. It's a way to help us stay on track. Looks like you scored the "Socialmente" scale the lowest. Start there or wherever you would like.*

Client: *I am overwhelmed. I can't sleep worrying about everything, how we are going to make it. I've just been in the U.S. for about a year. Found a place to live, got my daughter enrolled in school, and found a job. I thought that after all I had been through, especially traveling across the desert with a 5-year-old (Client elaborates harrowing story of leaving Mexico to travel to the U.S.) to get here, that things were going well. Then the things at work started.*

Therapist: *Wow, what a story, you have been through some tough times and have prevailed looking for a better life for your daughter. What is happening at work?*

The initial ORS score is an instant snapshot of how clients view themselves, bringing an understanding of their experience to the opening minutes of a session. With this client, within 2 min, the therapist knew that she was in significant distress, well under the average outpatient psychotherapy intake (18–20), and that she was especially experiencing hardship in the social (work, school, friendships) domain of her life. A cultural opportunity was also presented, which is followed up in the exchange below.

Client: *Thanks, that is what I am looking for. Work is really getting me down. I started at a real estate company as a receptionist because they wanted someone who spoke Spanish. I thought it was going great and I could eventually get my real estate license. But the manager said that people were complaining about my English, that I had too much of an accent. I think it is him, that he thinks I have too much of an accent. I don't think he likes immigrants, especially from Mexico. The previous receptionist was Spanish speaking from the U.S. and spoke English without an accent. He makes me repeat everything at least three times. No one else does that. So he moved me off of reception and cut my hours. I can't afford that! He says it's because things are slow now, but I think it is because he doesn't like my English. I think it is, what do you call it, discriminación?*

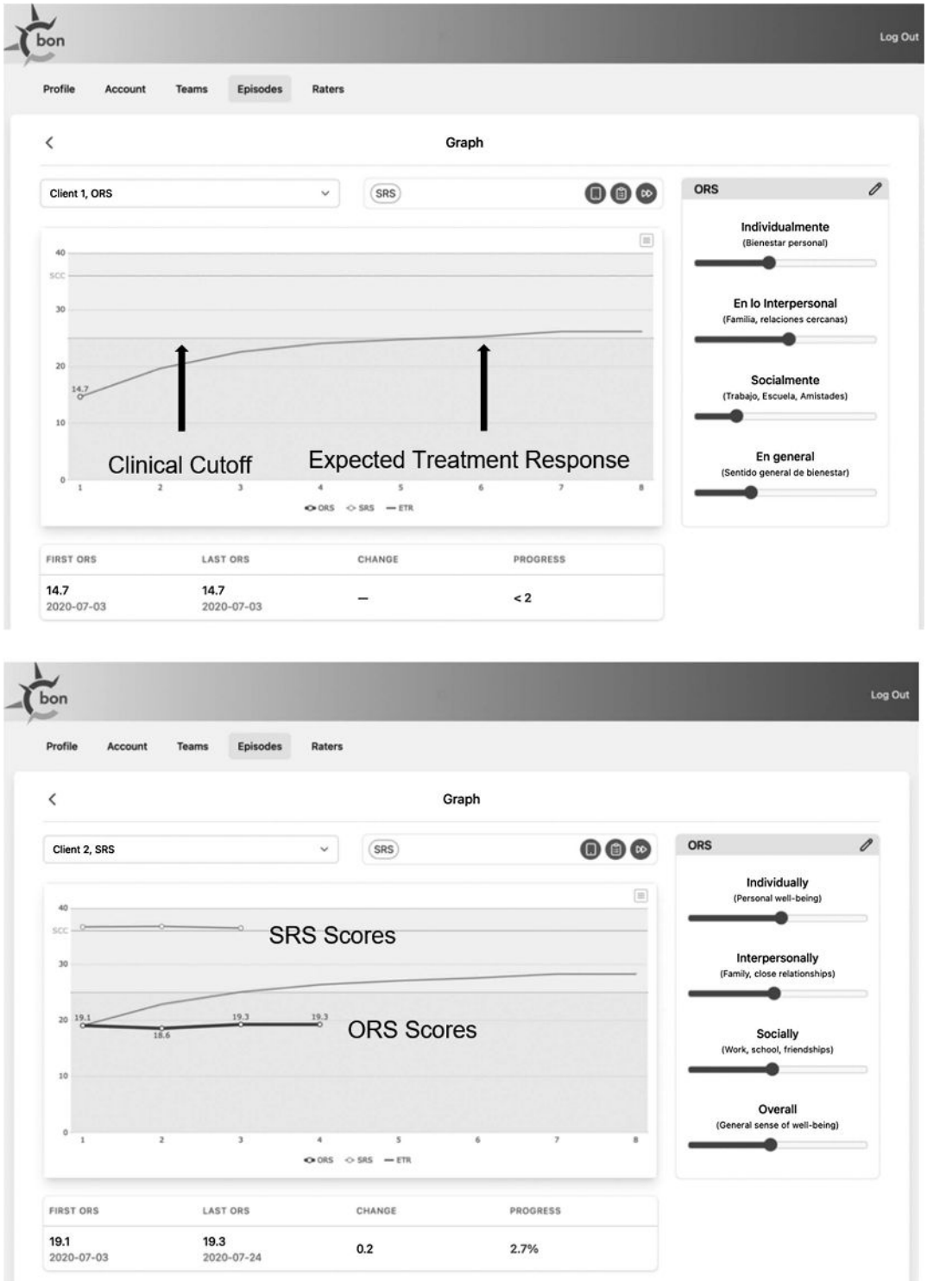
Therapist: *Yes, discrimination. No wonder you are distressed and feeling overwhelmed. After all you have been through, you now face a boss who is discriminating against you because you are Spanish speaking (Therapist holds up iPad and Points to ORS). So, does your lowest mark on the "Socialmente" scale represent this situation at work where you are being discriminated against because of your English? (Client says "yes."). And that situation (therapist points to other domains on the ORS) is affecting all these other aspects of your life? (Client nods yes.).*

Conversations generated by client scores on the ORS are openings for therapists to inquire about reasons for service, views on precipitating and contextual factors, impact of the problem in clients' lives, and thoughts about general directions for problem resolution. The ORS not only helped create an opportunity to discuss the discrimination but also facilitated the therapist's ability to follow the client's lead and enhance cultural comfort. Clients usually score the lowest on the scale that represents the reason for service, and the therapist invites them to start there (or anywhere else they find useful). The therapist connects the client's discussion of the reason for service to how they filled out the ORS to a specific mark on a specific domain. This helps the client and therapist to collaboratively define a starting point—a shared understanding of the problem, the client's preferred focus of therapy, and what success will look like.

Therapist: *What do you think it would take or what would be different at work that would lead to your mark on the Socialmente scale moving just one cm to the right?*

Figure 1

Client 1, Outcome Rating Scale (ORS) and Client 2, Session Rating Scale (SRS)



Note. ETR = expected treatment response; SCC = SRS Clinical Cutoff.

Client: *I think if I had some kind of plan that would increase my confidence to face the boss and somehow deal with the discrimination differently.*

Therapist: *Okay, that makes sense. Let's talk about what you can do at all levels of this, from how you interact with him to what options you have on a larger scale. But first, what are your ideas about how to approach this so that you feel less overwhelmed and more confident?*

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 calibrated to their idiosyncratic circumstances. The therapist then can ask, "What do you think it will take to move your mark just one centimeter to the right? What needs to happen out there and in here?" Asking clients about their theory of change (Duncan & Moynihan, 1994) not only privileges client perspectives above theoretical predilections but also honors potential cultural and indigenous solutions. Ensuing conversations can revitalize clients' hope and belief in their capacity to effect meaningful change, bringing to bear potent client factors in the resolution of difficulties, enacting the APA multicultural guidelines' call for strength-based interventions.

After the first session, the client's score answers the question in Lambert's (2001) definition of patient-focused research, "Is this particular treatment working for this patient?" (p. 147). Nonresponding clients are engaged in a collaborative search for new directions, while benefitting clients are empowered to see gains as resulting from their own efforts, another example of the APA guidelines' call for strength-based interventions.

Every conversation about change or the lack of change sets the occasion for not only unfolding and expanding experiences, constructing new meanings, and unearthing new avenues out of the client's dilemma but also for opportunities for cultural humility. PCOMS essentially serves as a communicative catalyst in which client and therapist engage in a constantly evolving conversation about the status of the client's problem and the therapy's role in helping resolve it.

The Session Rating Scale

The use of the SRS continues the value of client privilege and opens space for the client's voice about the alliance and therapist/client fit, specifically aiming to identify alliance ruptures before they negatively impact outcome. The SRS provides a structure to address the alliance, allows an opportunity to fix any problems, and demonstrates that the therapist is committed to forming good relationships. The SRS also encourages ethnic/cultural/racial/orientation differences to be transparently and routinely discussed.

The SRS translates what is known about the alliance into four visual analog scales (relationship, goals and topics, approach or method, overall), based on Bordin's (1979) classic delineation: the relational bond and the degree of agreement between the client and therapist about the goals and tasks of therapy. The SRS is scored similarly to the ORS by adding the total of the client's marks on the four 10-cm lines.

Clinical Process of the SRS

The SRS helps build a strong alliance, encouraging space for therapists to not leave it to chance. It also provides a mechanism to address cultural beliefs and ideas that may be salient to treatment and the relationship. By routinizing the asking for and receiving client feedback about their experience of therapy, the SRS promotes openness to client perspectives, laying the foundation for cultural comfort. But it requires therapists to embrace that they can never fully understand a client's cultural experience, with only continued efforts to gain a closer approximation. The SRS begins with a rationale.

Therapist: *Before we end today, I want to ask you to fill out another brief form. It's called the Session Rating Scale. It's kind of like taking the temperature of our meeting today. Was it too hot or too cold? Do I need to adjust the thermostat to make you feel more comfortable? The ultimate purpose is to make every possible effort to make our work together beneficial for you and to make it go the way you want it to. If something is amiss, you would be doing me the best favor if you let me know because then I can do something about it. Would you mind doing this for me?*

Beyond being an alliance measure, the SRS represents a nuanced relational process designed to ensure that clients feel safe about offering feedback. This requires therapist comfortability about asking for feedback and a graceful response that accommodates the work to the feedback—an authentic desire for a frank discussion about client preferences regarding the alliance.

High scores on alliance measures are the norm rather than the exception, whether given face-to-face or not. Although high scores are often attributed to social desirability or demand characteristics, research has not found these variables important (Reese et al., 2013). High scores are more likely because of the difficulty in providing feedback in interpersonal situations in general, and particularly in hierarchical, helping relationships (Duncan & Sparks, 2019). Clients must trust that there will not be ramifications to offering negative feedback. Consequently, high scores may or may not reflect a positive alliance. Therapists must continue to coax feedback while building trust that feedback will solidify the alliance.

Although the alliance is discussed at each session, it gains additional priority if the client is not benefiting. If change has not occurred by 3–6 sessions (depending on the therapist and the setting) or progress is in the red, (50% or less of the ETR; see Figure 1), the first approach is to focus on the alliance. Here, the therapist simply goes through the SRS item by item. Eliciting client responses in detail can help therapists and clients alike get a better sense of what may not be working. Such occurrences create a cultural opportunity to entertain how culture, including therapist and client differences, is a contributing factor to the lack of success.

Client 2, the SRS. The client, a 42-year-old African American, cisgender man, and the therapist, a 64-year-old White, cisgender man, illustrate how racial differences can be explored via discussion of the alliance. The client presented with general feelings of malaise, marital troubles, and a lack of motivation at work. His initial ORS score was 19.2, reflecting distress typical of clients entering outpatient psychotherapy. The therapist and client, over the first two

sessions, agreed to approach the client's concerns from an existential framework, highlighting the thematic meaning of his malaise and angst as well as cognitive strategies to address the client's stated propensity to "make mountains out of molehills." The client declined marital therapy.

At the beginning of the fourth session, the client's graph was a flat line (see Figure 1), with no benefit depicted. The therapist reviewed what had been done so far and asked the client if he had any ideas about the lack of benefit and what could be done differently at this point.

Therapist: *Doesn't look like things have improved (Therapist and client look at graph). What do you think that means, particularly regarding what we should do today?*

Client: *I am not sure. I find our conversations helpful, and the exploration of meaning has been thought provoking, but nothing has put a dent in my problems or how I feel. I can see that the self-talk and relaxation strategies could be useful, but maybe not for me.*

Therapist: *Let's explore some possibilities for things we might do differently in this session to get things turning in the right direction. But first, with your agreement, I'd like to go over the items on this SRS to make sure you are getting what you are looking for from me and our time together. I know that you rated our previous sessions as going well but sometimes alliance concerns can contribute to a lack of benefit, that somehow the therapy or me specifically are not on target in some way.*

Client: *Sure, anything that might help.*

Therapist: *Great. Thanks. The first item covers whether you feel heard, understood, and respected. Do you think I am getting where you are coming from? Am I missing something here? I perhaps should have addressed this directly in our first meeting. I was wondering if you thought it might be helpful to address our racial difference and if I needed to adjust anything because of it. I would greatly appreciate your help in understanding these things because coming from a white privileged position, I am certain that I have inevitable blind spots. Is my whiteness getting in the way here?*

Client: *You know, that's a good question. I never really think much about it because, you know, as a Black man, I deal with the white majority every day, especially in my work, and have dealt with it all my life. So, I didn't give your whiteness any space in my head because it is ubiquitous, as they say, like the air that I breathe. But now, I am wondering how you can understand me as a Black man, the pressures I feel in my all-white law firm, both colleagues and clients, and the enormity of the burden I feel to make my marriage work coming from both my wife and our deeply religious families, as well as my position in our church.*

Therapist: *You, of course, are right. There is no way I can completely understand what you have been through as a Black man in a white majority world. Similarly, your experience of burden resulting from your position in the Black community, church, and family are also impossible for me to understand the complexities and pressures involved. Do you think if we explore these issues more fully so that I might achieve a better understanding, that it will help and enable you to benefit from therapy? Or do you think we should discuss you moving on to a different therapist, a person more in tune with your experience as a Black man?*

Client: *I think we should discuss what I am going through as a Black man experiencing the concerns I have raised. Adding that dimension, I think, will help you understand more. I like talking to you and I think this will be the part that has been missing.*

This conversation, of course, could have happened without the SRS. Like the ORS provides a platform for understanding the client's experience, discussing client benefit, and collaboratively altering therapy, the SRS enables a structure for conversations about the relationship and alliance—to demonstrate a sincere curiosity and desire to understand the client's experience, including how their social locations may be salient. Specific to MCO with this client, the SRS promoted cultural humility with the open stance to learning about his perspective of the therapeutic alliance through a multicultural lens. Within this process, a cultural opportunity arose due to the lack of benefit that enabled the therapist to better understand the client's unique challenges as a Black man. The SRS can also facilitate a sense of cultural comfort in that it provides a mechanism to initiate conversations that might be more difficult for therapists to broach without a structure in place. Finally, the SRS empowers therapists to elicit and embrace feedback and therefore may enhance cultural comfort. It provides a logical place for such conversations to occur if they do not do so naturally during treatment, enabling the space to make humble attempts at getting closer to the client's unique experience.

Conclusions

Beyond ensuring representative diversity and educating dominant culture practitioners about privilege and other biases, less has been proposed about *doing* MCO with *this* client with *this* therapist. PCOMS provides an example of how any feedback system can address client experiences of marginalization and discrimination as well as differences between client and therapist. Any outcome measure can include discussions of larger social impacts on symptoms. Clinicians using symptom-based outcome measures need only identify the most distressing items and ask the client if they have any ideas about the factors that contribute to the distress. Systems that do not include routine alliance measures can consider adding one to facilitate conversations about the influences of therapist-client differences on the therapeutic relationship.

PCOMS provides a way toward a multicultural orientation and the APA multicultural guidelines, including the call for a strengths-based approach, but our intention was not to suggest that it

offers a panacea for addressing diversity, nor that PCOMS as an intervention to improve outcomes is without heterogeneity of results or methodological criticisms (Duncan & Sparks, 2020; Østergård et al., 2020), nor that PCOMS is the preferred feedback system to implement MCO. Rather, we suggested that the collaborative, client privilege, and social justice heritage of PCOMS positioned it to provide an example structure to address marginalization and therapist–client differences in therapy. Implementing MCO takes a sustained effort to include clients and embrace their feedback—to not reduce psychotherapy to the medical model equation of diagnosis plus prescriptive treatment equals cure, nor clients to cultural, ethnic, racial, or gender stereotypes or pharmaceutical-sponsored checklists, nor the proclivities of enlightened psychotherapists who know better than clients what they need.

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Received September 5, 2023
Revision received February 5, 2024
Accepted February 7, 2024 ■