Measurement-Based Care and Cultural Responsiveness

Robert J. Reese, PhD
Barry L. Duncan, PsyD

While the case has been made that measurement-based care (MBC) is an evidenced-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 cultural responsiveness. This article proposes that MBC can encourage a communicative process that promotes cultural humility, creates opportunities for cultural exploration, and enhances therapists' cultural comfort—the three pillars of a multicultural orientation (MCO; Hook et al., 2017)—to address marginalization and therapist client differences. Using one evidence-based MBC approach with a heritage of collaborative and social justice processes to illustrate, we suggest that systematic client feedback can provide a structure to address diversity, oppression, and privilege in psychotherapy that all MBC approaches can implement.

The Partners for Change Outcome Management System (PCOMS)

With PCOMS, science caught up with the clinical process rather than vice versa. After the measures were developed, Duncan created the clinical process of PCOMS based on two years of private practice and the supervision of graduate students in a multicultural community clinic and detailed it in the first PCOMS manual (Duncan & Sparks, 2002, now in its fourth edition). Over time, psychometric studies were published, and Duncan, Reese, and colleagues completed eight randomized clinical trials (see Duncan & Reese, 2024). PCOMS, while emerging from everyday practice and starting as a purely clinical process with an aspiration to privilege the client (Duncan & Moynihan, 1994) and promote socially just practice, evolved to be both a normative and communicative system (Duncan & Reese, 2013; Sparks & Duncan, 2018).

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) asserts:

> Consumer involvement in all decisions that affect care also speaks to the issues of multiculturalism and social justice. Client centered or directed care necessarily includes a recognition of the disparate power that exists between the provider and consumer of services, especially for those not of the dominant culture as well as the traditionally disenfranchised, and transparently seeks to address the disparity…In addition, the infrastructure of mental health itself (i.e., diagnosis and prescriptive treatment) often leaves little room for the unique views of those whose culture, race, gender, gender expression, ability, age, or socioeconomic status differ from

continued on page 63

> typical providers steeped in mainstream psychology…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).

Operationalizing a Multicultural Orientation

PCOMS employs two 4-item scales, one focusing on outcome, the Outcome Rating Scale or ORS (Miller et al., 2003) and the other on the therapeutic alliance, the Session Rating Scale or 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 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). These major domains of life offer a general framework of human existence to which clients add the intimate details of their lived experience via therapeutic conversation. The content-free dimensions of the ORS allow clients to describe the meaning of their scores without preconceived theory, symptom, diagnostic, or therapist-derived constraints, running counter to practices that pathologize clients of color and other historically marginalized groups at higher rates (Sue et al., 2022). Thus, client accounts retain the richness of real life, including the unique back-stories that contextualize their dilemmas, including the possibility of oppression and discrimination.

Outcome Rating Scale Clinical Process and Multicultural Orientation

Duncan and Reese (2024) provide a clinical example that highlights how the ORS is used to direct efforts within a session, across treatment, and how it can support MCO. First, the therapist oriented the client, a cisgender woman who recently immigrated from Mexico, to the ORS. In doing so, the therapist noted that the measure was used to ensure her perspective stayed central to treatment. This could be considered a dimension of cultural humility, the overt commitment to the client's perspective.

Second, the client completed the ORS and scored below the clinical cut score of 25 (14.7) indicating she was experiencing significant distress. Third, in reviewing the item scores, the therapist noted that the Social (work, school, relationships) item was rated the lowest and used it as a starting point to understand the client's reason for seeking treatment. The client then shared that her job was stressful and that she was experiencing discrimination from a boss who ridiculed her Spanish accent. This provided a cultural opportunity for the therapist and client to consider, communicating both empathy and wanting to better understand what occurred regarding her workplace discrimination. The items on the ORS go beyond an internal, symptom focus and consider social and contextual factors, including marginalization and oppression, that may be impacting this client's well-being. Such a structure also can empower therapists and clients to address these issues more directly, inspiring cultural comfort for the therapist. Asking about potential sociocultural issues is interwoven into the fabric of the ORS, making such conversations potentially easier and inspiring confidence in therapists to invite clients to discuss such issues. PCOMS data and clinical

continued on page 64

process continue to help inform treatment progress, invite further collaborative opportunities for client benefit, and continue to communicate a stance of cultural humility.

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.

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. 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.

Although the alliance is discussed at each session, it gains additional priority if the client is not benefiting. 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, are contributing factors to the lack of success.

Session Rating Scale Clinical Process and Multicultural Orientation

Administered at the end of the session, the SRS evaluates the working alliance and offers further opportunity to incorporate MCO. Duncan and Reese (2024) state, "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" (p. 106). They provide a second example to demonstrate how the SRS is administered, can foster a collaborative relationship, and raise issues, including cultural, identity, or other issues that may be influencing treatment and/or the relationship.

The client in the example was a 42-year-old African American, cisgender man who was making little progress after four sessions of treatment. Although the SRS scores did not indicate an issue with the alliance (score was above the cut-score of 36), the therapist used the first item "I felt/or did not feel heard, understood, and respected" to ask if the racial difference between them (therapist was a white man) might impact the client feeling understood in a way the therapist could be missing. This led to a deeper discussion and recognition that the client's social locations were not a salient part of his story being shared, and a recalibration of the therapeutic conversation. In this instance, the SRS was used in a practical way to better understand the lack of progress in therapy from a multicultural framework. The SRS ensures there is space and structure for conversations about the relationship. The example demonstrated cultural humility in the willingness to gain the client's perspective and understanding about how issues of race/gender may be impacting both treatment and the working relationship. Further, the clinical process created a cultural opportunity and, like the

continued on page 65

ORS, can foster cultural comfort by having a platform to help initiate and support these discussions. It can help normalize and encourage process-focused discussions about how client-therapist social identities and other socio-cultural variables may influence both the relationship and treatment.

Conclusions

Although there have been great strides regarding diversity, equity, inclusion, and multicultural competence, a need remains to translate these values into actionable behaviors in psychotherapy. PCOMS provides an example of how any feedback system can address client experiences of marginalization as well as differences between client and therapist. The ORS tends to cast a larger net on client difficulties beyond symptom focused instruments, but any outcome measure can include discussions of larger social impacts on symptoms. While pharmaceutical sponsored symptom check lists seek to categorize the complexities of human experience into discreet conditions that lead to psychotropic interventions, psychotherapy requires a more nuanced understanding of distress contextualized by a broader social understanding of behavior. 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 American Psychological Association multicultural guidelines (2018), including the call for a strengths-based approach. However, 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, 2019; Østergård et al., 2018), nor that PCOMS is the preferred feedback system to implement MCO. Rather, we suggest 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 a multicultural orientation 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, gender stereotypes or pharmaceutical sponsored checklists, nor the proclivities of enlightened psychotherapists who know better than clients what they need.

References

American Psychological Association (2018). APA adopts new multicultural guidelines. *Monitor on Psychology, January, 49* (1), 47. https://www.apa.org/monitor/2018/01/multicultural-guidelines

Boswell, J. F., Hepner, K. A., Lysell, K., Rothrock, N. E., Bott, N., Childs, A. W., Douglas, S., Owings-Fonner, N., Wright, C. V., Stephens, K. A., Bard, D. E., Aajmain, S., & Bobbitt, B. L. (2023). The need for a measurement-based care professional practice guideline. *Psychotherapy, 60*(1), 1-16. https://doi.org/10.1037/pst0000439

de Jong, K., Conijn, J. M., Gallagher, R. A. V., Reshetnikovea, A. S., Jeij, M., &. Lutz, M. C. (2021). Using progress feedback to improve outcomes and reduce drop-out, treatment duration, and deterioration: A multilevel meta-analysis. *Clinical Psychology Review, 85*,

continued on page 66

https://doi.org/10.1016/j.cpr.2021.102002

Duncan, B., Miller, S., Sparks, J., Claud, D., Reynolds, L., Brown, J., & Johnson, L. D. (2003). The session rating Ssale: Preliminary psychometric properties of a "working" alliance measure. *Journal of Brief Therapy, 3,* 3–12.

Duncan, B., & Moynihan, D. (1994). Applying outcome research: Intentional utilization of the client's frame of reference. *Psychotherapy, 31,* 294–301.

Duncan, B., & Reese, R. J. (2013). Clinical and scientific considerations in progress monitoring: When is a measure too long? *Canadian Psychology, 54,* 135–137.

Duncan, B. L., & Reese, R. J. (2024). The evolution of feedback: Toward a multicultural orientation. *Psychotherapy, 61*(2), 101–109. https://doi.org/10.1037/pst0000524

Duncan, B. L., & Reese, R. J. (2015). The partners for change outcome management system (PCOMS) revisiting the client's frame of reference. *Psychotherapy, 52*(4), 391-401. https://doi.org/10.1037/pst0000026

Duncan, B., & Sparks, J. (2002). *Heroic clients, heroic agencies: Partners for change.* Author.

Duncan, B., & Sparks, J. (2019). When meta-analysis misleads: A critical case study of a meta-analysis of client feedback. *Psychological Services*. http://dx.doi.org/10.1037/ser0000398

Hook, J. N., Davis, D., Owen, J., & DeBlaere, C. (2017). *Cultural humility: Engaging diverse identities in therapy.* American Psychological Association. https://doi.org/10.1037/0000037-000

Miller, S. D., Duncan, B. L., Brown, J., Sparks, J., & Claud, D. (2003). The outcome rating scale: A preliminary study of the reliability, validity, and feasibility of a brief visual analog measure. *Journal of Brief Therapy, 2,* 91–100.

Østergård, O. K., Randa, H., & Hougaard, E. (2018). The effect of using the Partners for Change Outcome Management System as feedback tool in psychotherapy—A systematic review and meta-analysis. *Psychotherapy Research, 30*(2), 195-212. https://doi:10.1080/10503307.2018.1517949

Reese, J., Duncan, B., & Clements-Hickman, A. (2024). Does practice generated data improve psychotherapy effectiveness (routine outcome monitoring)? In F. Leong, M. Constantino, & C. Eubanks (Eds.), *APA handbook of psychotherapy* (Vol. 2; pp. 192-211). American Psychological Association.

Sparks, J., & Duncan, B. (2018). The partners for change outcome management system: Aboth/and system for collaborative practice. *Family Process,* 1-17. https://doi.org/10.1111/famp.12345

Sue, D. W., Sue, D., Neville, H. A., & Smith, L. (2022). *Counseling the culturally diverse: Theory and practice* (9th ed.). Wiley.

Society for the Advancement of Psychotherapy