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**Evidence-Based Practice, Practice-Based Evidence,
and Contextual Participant-Driven Practice**

Frederick T. L. Leong, *Editor-in-Chief*

Jennifer L. Callahan, Jeffrey Zimmerman,

Michael J. Constantino, and Catherine F. Eubanks, *Associate Editors*

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DO PRACTICE-GENERATED DATA IMPROVE PSYCHOTHERAPY EFFECTIVENESS (ROUTINE OUTCOME MONITORING)?

Robert J. Reese, Barry L. Duncan, and Alyssa L. Clements-Hickman

Routine outcome monitoring (ROM) in psychotherapy is the systematic use of outcome (e.g., symptom reduction) and/or process (e.g., therapeutic alliance quality) measures to help track a client's progress across the course of treatment. Such assessments assist the therapist in responding to the evolving and momentary needs of clients and making adjustments to treatment, if necessary. ROM is a simple process conceptually, but how it is implemented has become more complex as different approaches have emerged.

The research has also become more complex. Early studies indicated that psychotherapy clients in a ROM condition demonstrated more treatment benefit than those in a treatment-as-usual condition (e.g., Lambert et al., 2001). More recent research, however, has painted an increasingly complicated picture that highlights how process and moderating variables can influence the effectiveness of ROM or cast doubt on its effectiveness altogether (e.g., de Jong et al., 2021; Østergård et al., 2020). These factors include treatment setting, treatment format, the outcome measures used, the ROM system/approach used, how ROM is operationalized, and attitudes of the therapist toward ROM, among others. This increased empirical nuance is a healthy and necessary step in the evolution of ROM-centered research and psychotherapy

research more broadly. Thus, it is important to carefully consider both the earlier research and the context and quality of the latest pertinent research on ROM.

The primary goal of this chapter is to provide a critical overview of the extant ROM research base. Before summarizing the empirical results, we provide a foundational understanding of ROM, including the rationale for using it in psychotherapy, proposed theoretical underpinnings, the different approaches that have emerged, and the accompanying values that undergird the outcome-monitoring process. Following the research review, we conclude with suggestions for future research and implementation recommendations for clinicians and clinical supervisors/trainers.

Notably, we settled on the term *routine outcome monitoring* for this chapter given that it is the most commonly used; however, it was not without some hesitation, for two main reasons. First, a review of the literature indicated that several terms have been used to describe similar processes. These include, among others, patient-focused research, patient feedback, client feedback, quality assurance system, feedback-informed treatment, patient-reported outcome measures, and measurement-based care. The variety of terms can create confusion for

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both researchers and clinicians and, indeed, it proved challenging to identify all the research given the various terms. Second, there are a variety of approaches and systems that fall under this umbrella term (e.g., Lambert et al., 2001; Sparks & Duncan, 2019). The lack of specificity may be problematic, as it lumps together approaches that have different levels of empirical support and have different processes that may or may not be critical. There is some evidence that the lack of uniformity has led to variable results, with less formal, systematic approaches yielding smaller effects (Krägeloh et al., 2015).

RATIONALE FOR ROM

ROM was originally developed for a singular purpose: to prospectively identify clients at risk for premature termination or poor outcomes even if they were to remain in care (Lambert, 2015). The need for this innovation has been well established. Although psychotherapy is a generally efficacious intervention that benefits many clients (Wampold & Imel, 2015), many others (roughly 20%) discontinue treatment prematurely before they can benefit (Swift & Greenberg, 2012). There are still other clients who do attend a clinically meaningful number of sessions but show no improvement, and approximately 5% to 10% who get worse in treatment (Crawford et al., 2016). Moreover, clinicians are generally not very good at judging their clients' risk for dropout or poor outcome (Chapman et al., 2012; Hannan et al., 2005). For example, Hannan et al. (2005) found that clinicians were only able to correctly and prospectively identify 1 of 26 clients (3.84%) who went on to have a poor treatment outcome, compared with a ROM-system algorithm developed with normative data that correctly identified 20 of 26 clients (77%).

Although it may be surprising that clinicians are poor at detecting what seems to be an obvious thing (a worsening level of client distress), there is seemingly at least one good reason for this. Therapists generally tend to overestimate their effectiveness, with most believing they are above average (e.g., Walfish et al., 2012). Yet, as reviewed

by Nissen-Lie et al. (Chapter 14, this volume) and Coyne (Chapter 15, this volume), it is well established that clinicians can vary significantly in their effectiveness. Thus, circling back to the original rationale for ROM, if an at-risk client can be reliably identified before dropping out or deteriorating (a process that clearly relies on more than clinician judgment/self-assessment of effectiveness), then therapists will have an opportunity to evaluate the reasons for the lack of progress and to modify treatment accordingly. Such a ROM-based process, or psychological "lab test" (Hannan et al., 2005), offers accountability for therapists and a means to having a more realistic, accurate appraisal of their performance that is based on clients' feedback of their progress and treatment experience.

THEORETICAL UNDERPINNINGS OF ROM

Michael Lambert, a pioneer in the development, research, and proliferation of ROM in psychotherapy, developed the Outcome Questionnaire system (OQ; Lambert, 2015) for the pragmatic reason that a normative-based algorithm was more accurate at identifying at-risk clients than therapists using only their clinical judgment. Despite this straightforward pragmatism, attempts have been made to attach theory or offer further rationale for how ROM positively influences psychotherapy outcomes. Many of these theoretical elaborations stemmed from the development of other ROM systems (beyond the OQ) that have different properties and putative processes that we discuss later in the chapter. Although there is limited empirical support for such theories or process rationales, we mention them because they help frame our discussion for future research and highlight possibly important process differences in ROM systems/approaches. Broadly, explanations for the benefit of ROM include that it can enhance the theory-common facilitative factors in treatment (e.g., therapeutic alliance; Duncan & Reese, 2015) and increase client engagement (Anker et al., 2009). From a theoretical perspective, feedback intervention theory and therapeutic assessment

(Carrier et al., 2012) have both been offered as possible explanations for ROM's promoting clinical mechanisms of change.

Therapeutic Alliance and Enhanced Common Factors

A common finding in psychotherapy science is that the therapeutic alliance is a consistent predictor of treatment outcome (Flückiger et al., 2018). It has been hypothesized that the use of ROM can promote client–therapist collaboration that fosters a better working alliance and increased client engagement in treatment. There is some support that ROM can benefit the therapeutic alliance, albeit most of it is indirect evidence. For example, Lambert et al. (2018) found increased benefit when clinical support tools (that includes administering a working alliance measure) were used with not-on-track (NOT) clients. More directly, at least two studies have found that clients who engaged in ROM with an alliance measure reported faster increases in alliance scores compared with clients in a treatment-as-usual condition without ROM or alliance measurement (Brattland et al., 2018; She et al., 2018).

Feedback Intervention Theory and Therapeutic Assessment

Carrier et al. (2012) presented feedback intervention (FI) theory and therapeutic assessment as two theoretical means for understanding the mechanisms of change promoted by ROM. Drawing mainly on industrial and organizational psychology, Kluger and DeNisi (1996) developed FI theory to explain the role of feedback in the process of influencing performance. Their theory draws on other theories (e.g., control theory, goal-setting theory) and hypothesizes that individuals can be motivated to change by having data that provides comparisons of current behavior to a standard or goal (actual vs. desired behavior) and that feedback based on this comparison can direct attention and influence behavior to reduce the gap between the two. Carrier et al. also highlighted the model of therapeutic assessment and the potential clinical benefit of collaboratively discussing assessment data that is personalized

and tailored to the individual; that is, such assessment can be used for therapeutic purposes rather than only for providing diagnostic information (Poston & Hanson, 2010).

DIFFERENT SYSTEMS OF ROM

According to Lambert (2015), a viable ROM system requires three components: a reliable and valid measure of client change, a normative-determined signal of notification of at-risk clients, and continuous progress monitoring. Together, these ensure that the system identifies not-on-track clients in time for remedial action. Providing the foundation of our current discussion of available systems, a 2015 special issue of *Psychotherapy*, "Progress Monitoring and Feedback," presented seven systems that meet Lambert's criteria, each with accompanying electronic tracking technology. One of those seven, the Counseling Center Assessment of Psychological Symptoms (Youn et al., 2015) is not included in our review given its narrow focus on the mental health needs of college students. Also not included in our review are systems specifically designed for youth (e.g., Contextualized Feedback System; Bickman, 2008) or a particular theoretical orientation (e.g., Systemic Therapy Inventory of Change; Pinosof et al., 2015). The systems that follow represent the most widely used, psychometrically validated, transtheoretical, and empirically supported ROM approaches.

First, in order of appearance in that special issue, is the aforementioned OQ (Lambert, 2015). The 45-item OQ (a 30-item version is also available) asks clients to estimate frequency of occurrence of 45 symptoms, emotional states, interpersonal relationship functioning, and social role functioning on a 5-point Likert scale. The OQ was designed to monitor client functioning at each session, the first measure to do so. The OQ also includes the 40-item Assessment for Signal Clients, designed for clients not benefiting, to assist clinicians with potential impediments to successful treatment, including poor alliance quality, low motivation, restricted social support, and stressful life events.

Second is the Partners for Change Outcome Management System (PCOMS; Duncan & Reese, 2015). Emerging from clinical practice and designed with the frontline clinician in mind, PCOMS employs two four-item scales, one focusing on outcome (the Outcome Rating Scale [ORS]; Miller et al., 2003) and the other on the therapeutic alliance (the Session Rating Scale [SRS]; Duncan et al., 2003). Unlike most outcome instruments, the ORS is not a list of symptoms or problems checked by clients on a Likert scale. Rather, it is a visual analog instrument that is individualized with clients to represent their distress and the reasons for service in three domains (personal, interpersonal, social). 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 & Sparks, 2002).

Third is the Clinical Outcomes in Routine Evaluation (CORE; Barkham et al., 2015) system. Using a 5-point Likert scale, CORE is a 34-item (10-item and five-item versions are also available for session-to-session use) measure of psychological distress in the domains of Subjective Well-Being, Problems, Life Functioning, and Risk. CORE also includes provider-completed forms designed to be administered pre- and posttherapy. Extensively used in the United Kingdom, CORE has been used not only to track client progress but also to benchmark patient outcomes at clinic and systems levels (Mellor-Clark et al., 2013). The large CORE data set has also promoted research on general psychotherapy effectiveness (Barkham et al., 2012), dose-effect curves (Stiles et al., 2015), and one of the largest studies ever of therapist effects (Saxon & Barkham, 2012).

Fourth is the A Collaborative Outcome Resource Network (ACORN; Brown et al., 2015). ACORN is a comprehensive clinical information system designed, via integration of data sets from multiple sources, to analyze data and increase the value of mental health services. Realizing that therapists and clients require brevity while researchers prefer comprehensiveness and psychometric rigor, the ACORN system balances these competing demands with the Adult Version II.

It contains 17 items rated on a 5-point Likert scale about the most common symptoms and problems reported by those seeking treatment. Ten of the items ask about clinical symptoms, social isolation/conflict, and functioning in daily activities (i.e., Global Distress Scale). Three items screen for substance abuse, and the remaining four items solicit client responses about the therapeutic alliance. ACORN has been at the forefront of ROM, especially with large systems of care, since the beginning.

Fifth is the Treatment Outcome Package (TOP; Boswell et al., 2015). The TOP system is unique in its comprehensive multidimensional focus (Kraus & Castonguay, 2010). The TOP Clinical Scales consist of 58 items assessing 12 symptom and functional domains. It can be administered at intake to aid in case conceptualization and treatment planning, at pre- and post-treatment for indication of treatment effectiveness, or at regular intervals (e.g., session to session) to assess progress over time. The TOP has also provided a natural anchoring point for community and training practice-research networks (PRNs; Castonguay et al., 2011), data-driven treatment initiatives (see Adelman, 2005), and community-based clinical trials on matching clients to therapists' measurement-derived strengths (Constantino et al., 2021). In addition to monitoring effectiveness, understanding therapist variability (Kraus et al., 2011), and providing data-driven predictions related to child welfare (Kraus et al., 2015), the TOP system has been particularly influential in training clinics, where it can help students acquire and develop clinical skills and conduct clinically relevant studies.

Sixth is the Behavioral Health Measure-20 (BHM-20; Kopta et al., 2015). The BHM-20 evolved from early work on the dose-effect relationship (Howard et al., 1986) as well as the phase model of mental health assessment and improvement (Howard et al., 1993). Although the latest version consists of at most 21 items, the BHM-20 is intended to be both comprehensive and efficient in its coverage of mental health syndromes. Using a 5-point Likert scale, the BHM-20

consists of a Global Mental Health instrument with three primary scales: Well-Being, Psychological Symptoms, and Life Functioning, each designed to evaluate the three phases of outcome (first rehabilitation, remediation, final rehabilitation; Howard et al., 1993). The BHM-20 also includes a Suicidal Monitoring Scale consisting of two items. A longer version (43 items) of the BHM is available, as well as the Psychotherapy Readiness Scale (five items, generally used in the first session) and the Therapeutic Bond Scale (six items). All of the instruments are optional and can be used as pre–post assessments or at every session.

Finally, a more recent system not included in the special *Psychotherapy* issue is feedback-informed treatment (FIT; Delgado et al., 2018). FIT, another U.K.-based ROM, includes two outcome scales in the public domain: the widely used Patient Health Questionnaire-9 (PHQ-9; Kroenke et al., 2001) and the Generalized Anxiety Disorder-7 (GAD-7; Spitzer et al., 2006). The PHQ-9 is a nine-item screening tool for depression, in which each item is rated on a 4-point Likert scale. The GAD-7 is a seven-item measure developed to screen for anxiety disorders, also rated on a 4-point Likert scale. FIT has been implemented in the national U.K. Improving Access to Psychological Therapies (IAPT) program, which offers protocol-driven, evidence-based psychological interventions for depression and anxiety disorders organized in a stepped care model (Clark, 2011). The FIT system not only has demonstrated improved outcomes but also is more cost-effective than usual care (Delgado et al., 2021).

Each of the preceding systems has similarities to and differences from one another, as well as strengths and weaknesses. The OQ is the first session-by-session ROM system and the most empirically validated; PCOMS is the briefest and is also empirically validated; CORE is the most widely used in Europe and has been extensively used in benchmarking and psychotherapy research; ACORN is the most multisourced system and combines brevity with comprehensiveness; the TOP includes the most extensive multidimensional

assessment and has provided a base for creating community and training PRNs; the BHM-20 also strives to balance brevity with comprehensiveness and provides a variety of optional measures addressing readiness, the alliance, and suicidal behavior; and finally, FIT offers widely used measures in the public domain and shows promise regarding both empirical validation and cost-effectiveness.

While the choice of which system best suits a particular agency or organization or individual is based on many factors, we present the following distinguishing factors based largely on the conclusions of a recent special section addressing ROM in *Psychotherapy Research*. In that issue, McLeavey and Moltu (2021), the editors, presented these conclusions: (a) ROM must be culturally relevant (e.g., Sun et al., 2021); (b) clinicians must perceive ROM to be practical or feasible (Kwan et al., 2021); (c) ROM must include an explicit rationale to ensure active client collaboration—the impact of ROM seems greatest with collaborative discussion (Brooks Holliday et al., 2021); and (d) significant training is required to maximize ROM impact (see the next section; Kwan et al., 2021). We add one other distinguishing factor, empirical support, which seems conspicuously absent from many discussions of ROM.

Cultural Relevance and Social Justice

The noted ROM systems all support a social justice paradigm via consciousness raising and ongoing self-examination (Goodman et al., 2004; Pieterse et al., 2013). All can examine therapist effects specifically related to cultural competence with underrepresented populations. Kopta et al. (2015), for example, provided a compelling example of differential effectiveness with racial/ethnic minorities and made a strong case that outcome data can help therapists to build new skills and reduce differences in outcome based on client factors.

A search among the approaches for the words *social justice* or *cultural competence*, however, brings few results. Returning to the 2015 special *Psychotherapy* issue, none of the reviewed approaches, except one, discuss cultural competence or social justice beyond providing data

to examine differential effectiveness. The PCOMS article devotes 50 lines of text to this important issue. Social justice has been a part of PCOMS since its inception (Duncan & Sparks, 2002). PCOMS represents a departure from expert-driven formulations that classify client distress from a theoretical or symptom vantage point, which are potential culprits of ethnocentric and cultural biases. The measures and process of PCOMS do not emphasize a diagnostic, symptomatic, or theoretical lens, and they permit the clients to frame their distress in a manner that is consistent with their preferences and worldview. In a benchmarking study, Reese et al. (2014) evaluated the effectiveness of using PCOMS with a racially diverse adult sample from low socioeconomic backgrounds with a depressive disorder and found effect sizes that were similar to broader ROM-focused clinical trial studies.

Reliability, Validity, and Practicality

All of the preceding systems have acceptable to excellent psychometric reliability and validity of their respective instruments, with extensive administration and research support. That leaves the length of the measures and their practicality for everyday clinical practice to be a distinguishing aspect. Feasibility is critical to practitioner acceptance given that most studies of ROM implementation cite barriers related to time of administration and overall burden to staff (Ionita et al., 2020). It is notable that most of the preceding systems have addressed the practicality issue either by design (PCOMS, ACORN, FIT) or by offering reduced versions of their original measures (OQ: 45 to 30 items; CORE: 34 to 10 or five items; BHM: 43 to 21 items) to accommodate every-session use.

There are, however, advantages to longer measures (Halstead et al., 2013). Longer tools are typically more reliable and valid than shorter ones and arguably offer better detection of behavioral health symptomatology and overall functioning, as well as specific predictions of ultimate outcomes and related variables. Comprehensive and multi-dimensional measurement systems are ideal for

research purposes, offering more domains for inquiry and depth of content.

That being said, there can also be disadvantages. Again, measures that are perceived as too long by psychotherapists prevent many from considering ROM or result in low compliance rates. For example, Barkham et al. (2015) reported that only about one third of their database includes completed CORE measures (longer or shorter versions). Moreover, longer measures are also susceptible to being relegated to periodic or pre-post measurement, which can result in the data's not being fully representative of actual practice.

Regarding the noted systems, the TOP (58 items) and the OQ (45 or 30 + 40 items for at-risk clients) are on the longer side of the continuum, the CORE-OM (34 or 10 or 5 items + pre-post) and BHM (43 or 21 items + 11 optional items) about in the middle, and ACORN (17 items), FIT (9 or 7 items), and PCOMS (4 + 4 items) fall toward the shorter side. The question of when a measure is too short or too long requires continued empirical investigation balanced with consideration of what a given organization is hoping to gain. Duncan and Reese (2013), from a purely practical perspective, answered the question of when a measure is too long with simply, "When clinicians won't use it" (p. 136).

Client Collaboration: Clinical Processes of ROM

As noted in a 2021 issue of *Psychotherapy Research* (McAleavey & Moltu), the collaborative use of ROM systems has become more in focus. ROM is now often defined with variations of these four components (Fortney et al., 2017; Kearney et al., 2015; Scott & Lewis, 2015): (a) routine administration of outcome measures, (b) practitioner review of data, (c) client review of data, and (d) shared decision-making and collaborative reevaluation of the treatment plan informed by data. Similarly, Krágeloh et al. (2015) suggested a five-category typology of ROM systems, ranging from Category 1 (ROM scores not fed back to clinician or client) to Category 5 (scores fed back to clinician and client, with a formalized structure to guide discussions). After reviewing 27 ROM studies based on

this typology, Krägeloh et al. (2015) concluded that the availability of formalized guidelines for clinician–client discussion of feedback was most highly associated with improved outcomes.

The recent attention to the clinical process of ROM is promising, and its delay is understandable. Most ROM systems arose from rigorous measure construction and psychometric research and were aimed at the prevention of treatment failure. An exception seems to be PCOMS, which emphasizes clinical process and client collaboration (Duncan & Sparks, 2019). The 2015 *Psychotherapy* special issue about ROM illustrates the differential attention of the noted ROM approaches to the collaborative clinical processes involved. A crude indication of the differences among the approaches can be gleaned from counting the lines devoted to clinical process: OQ—30 lines of text, PCOMS—170 lines, CORE—0 lines, ACORN—24 lines, TOP—39 lines, and BHM—22 lines.

THE ROM EVIDENCE BASE

Although all of the systems described here have established psychometrics and supporting data regarding outcome improvements and myriad psychotherapy and client variables, only two have extensive randomized clinical trial (RCT) support for the benefits of ROM and ROM-based feedback: the OQ and PCOMS. A recent meta-analysis (de Jong et al., 2021) reported that of the 58 included trials, the OQ accounted for 38% of the available evidence and PCOMS accounted for 36%, while the rest of the included ROM approaches were used in only one or two studies. Both the OQ and PCOMS were included in the Substance Abuse and Mental Health Administration's National Registry of Evidence-Based Programs and Practices. The only other of our reviewed systems that has conducted at least one RCT is the FIT of Delgado et al. (2018). The empirical evidence for these three systems is reviewed later.

We identified eight ROM-focused meta-analyses (Kendrick et al., 2016; Knaup et al., 2009; Lambert & Shimokawa, 2011; Lambert et al., 2003,

2018; Østergård et al., 2020; Pejtersen et al., 2020; Shimokawa et al., 2010), and all but 14 studies across them used the OQ-45 or the ORS that are used in the OQ and PCOMS approaches. Within those studies, there was little homogeneity in the processes used (e.g., measures being discussed with clients) other than that outcome measures were administered throughout treatment and the information was provided to clinicians to evaluate treatment progress.

Early research on ROM generally found positive effects (Knaup et al., 2009; Lambert & Shimokawa, 2011). For example, Lambert and Shimokawa's (2011) meta-analytic review of nine studies using the OQ and PCOMS with over 6,700 clients indicated that clients in the ROM-based feedback condition had less than half the odds of experiencing deterioration and at least 2.6 times higher odds of achieving reliable change than clients in a treatment-as-usual (TAU) condition (with no ROM-based feedback). Given the encouraging results and the clinical practicality, there has been increased interest and a proliferation of studies in the last 10+ years. With this expansion of ROM research has come increased scrutiny to redress previous limitations of research; evaluate its use with different client populations (e.g., children and adolescents), outcome measures, treatment issues (e.g., eating disorders, substance use), formats (e.g., group), and settings (e.g., inpatient, schools); and evaluate variables that moderate/mediate its efficacy (e.g., therapeutic alliance, therapist variables).

More recent meta-analyses provide an overall positive, but mixed, picture. Kendrick et al. (2016) concluded, based on 17 studies, there was "insufficient evidence" (p. 2) in support of ROM's efficacy due to study design weaknesses (e.g., risk of bias, inadequate masking). When focusing only on the studies that used the OQ-45 and ORS as outcome measures to evaluate mean pre- and posttreatment scores, they reported that the findings did not find clients in the ROM condition to have superior outcomes to TAU clients. However, they did report across 10 studies that not-on-track (NOT) clients in the ROM condition had better treatment outcomes than

TAU clients who were identified by the ROM algorithm as being NOT.

Lambert et al. (2018) reviewed 24 studies focused on the OQ or PCOMS, and 18 indicated that clients in a ROM condition had better treatment outcomes compared with those in a TAU condition, with an overall small-to-moderate weighted standardized mean difference (SMD) of 0.14. As with the Kendrick et al. (2016) review, the largest effect was found for clients identified as NOT (SMD = 0.33), with significantly lower deterioration rates and approximately double the rates of reliable or clinically significant change. For the OQ studies, an important dimension to consider is those studies that evaluated the inclusion of clinical support tools. In these six studies, the weighted effect size increased to SMD = 0.49 for NOT clients, with significantly lower rates of deterioration and higher rates of reliable or clinically significant change (Lambert et al., 2018). Moreover, the odds of improving in the NOT feedback condition were 1.89 times more likely than the TAU condition, and the odds of deteriorating were 0.61 times less likely. Overall, the multiple meta-analyses converge in concluding that the OQ is of most benefit for clients who are at risk for dropping out of treatment early. Thus, feedback systems should include a normative data dimension that allows for identifying clients at risk for premature termination.

Recent ROM studies not included in the meta-analyses, or that have been conducted since then, also provide a more complicated picture of the benefit of ROM. For example, in a ROM quasi-experimental (before-and-after) study that used a computer-generated algorithm to give feedback to clinicians using PHQ-9 and GAD-7 scores (Delgadillo et al., 2017), researchers did not find significant differences between the quasi-control condition and the ROM condition but did find that using ROM resulted in clients' achieving the same outcomes in fewer sessions. In a follow-up RCT study, however, Delgadillo et al. (2018) found significant differences for NOT clients. Given that there are differences within each system and the newest meta-analytic studies

have focused on PCOMS, we break down the findings for each system further.

There have been multiple recent meta-analyses involving the PCOMS, including the Lambert et al. (2018) study already discussed and two that are exclusive to PCOMS (Østergård et al., 2020; Pejtersen et al., 2020). In the Lambert et al. (2018) study, six of the nine studies reviewed found statistically significant treatment gains on the ORS for the feedback condition over TAU. Collectively, the nine PCOMS studies indicated larger treatment gains on the ORS compared with TAU clients (small-to-medium standardized effect size, SMD = 0.40). This included all clients ($N = 2,272$), not just those NOT. Specific to reliable change, feedback clients were more than twice as likely to incur reliable improvement compared with TAU clients.

The other PCOMS-focused meta-analyses (Østergård et al., 2020; Pejtersen et al., 2020) were decidedly more mixed. Pejtersen et al. concluded that feedback was not helpful for improving well-being for clients. This study highlighted an important concern that influenced their methodology that we consider more fully later in the future research section. Namely, they noted that previous RCTs for PCOMS used a single outcome measure, the ORS, which is part of the intervention. This is a potentially critical point that has been raised by others (e.g., Duncan et al., 2021; Lambert et al., 2018), that using the same measure for the intervention and the outcome may introduce bias.

To address this concern, Pejtersen et al. (2020) opted to use the number of sessions treated as an outcome for studies that only used the ORS as an outcome measure. Unfortunately, this outcome is problematic as a valid measure. An argument could be made that clients who are NOT would be hypothesized to attend more sessions. Research has supported this (e.g., Shimokawa et al., 2010). This is intuitive and fits the rationale for ROM, but a competing issue is that PCOMS research has found that clients in a ROM condition improve more rapidly and ultimately require fewer sessions (e.g., Janse et al., 2020; Reese et al., 2010). Due to these competing

issues, it is unclear if sessions attended is a viable means to evaluate the benefits of PCOMS.

However, Pejtersen et al. (2020) did evaluate six studies that used an alternate outcome measure and found a standardized effect size of Hedges' $g = .03$ and concluded that feedback did not benefit client treatment outcome. This certainly needs to be further addressed, and yet we want to be cautious of conclusions that are based on a small number of studies that were heterogeneous in the treatment formats and populations, and uneven with protocol adherence. Of the five studies that found no benefit for feedback on different measures, one was conducted in an inpatient setting with adolescents (Lester, 2012), a second focused on outpatient therapy in a community mental health agency (Kellybrew-Miller, 2015), a third addressed group therapy for adults with an eating disorder (Davidsen et al., 2017), a fourth was in an emergency psychiatry setting with adults (van Oenen et al., 2016), and the fifth was in an outpatient setting with adults (Rise et al., 2012, 2016). Given that three of the studies were with more severely distressed populations, this dimension should be considered further as a potential limit of how ROM is used with those who are more distressed. Yet, a bigger shadow cast over these studies is that three of the five studies (Kellybrew-Miller, 2015; Lester, 2012; Rise et al., 2012, 2016) averaged fewer than four sessions (e.g., 2.2 sessions in Kellybrew-Miller and 1.7 sessions in Lester) and the other two did not follow either parts of or the entire ROM protocol (Davidsen et al., 2017; van Oenen et al., 2016).

Why/How Does ROM Work?

There are no direct comparison studies of ROM approaches to evaluate differential benefit. Research that has attempted to address this question has largely done so by altering or evaluating the ROM process or by looking at therapist variables. A couple of studies have attempted to add (Burlingame et al., 2018) or exclude (Mikeal et al., 2016) an alliance measure for ROM, with neither study finding that such inclusion or exclusion impacted treatment outcomes. Burlingame et al. (2018) did

find that including an alliance measure in group therapy resulted in fewer clients deteriorating. A third study (Janse et al., 2020) found that using a "high-intensity" (using PCOMS) form of ROM compared with "low intensity" (completion of the Symptom Checklist-90 every fifth session) resulted in feedback's being more efficient and having fewer dropouts. Shimokawa et al. (2010) summarized three OQ studies that evaluated if both therapists' and clients' seeing the results influenced outcome rather than just the therapist. Overall, the results indicated a greater likelihood of achieving reliable change when both saw the results but did not find significance when evaluating pre-post means.

Other ROM research has focused on therapist factors. For example, de Jong and colleagues (2021) found that the actual effect of ROM on client outcomes was moderated by therapists' attitudes toward ROM; that is, for therapists with more positive versus negative attitudes, the beneficial impact of ROM was greater. Therapists generally tend to hold neutral to positive attitudes about ROM (Cooper et al., 2019; Jensen-Doss et al., 2018), but therapist characteristics (e.g., theoretical orientation, clinical setting) and methodological differences (e.g., attitude measure used) appear to influence such attitudes. For example, Kaiser and colleagues (2018) found that therapists who endorsed using a cognitive-behavioral framework had significantly more positive attitudes toward outcome monitoring compared to those who used humanistic or existential frameworks.

Professional self-doubt is one characteristic that might influence ROM. Professional self-doubt refers to doubts about one's ability to effectively help clients (Orlinsky & Rønnestad, 2005). A few studies have been published showing that some degree of professional self-doubt might be beneficial to the therapeutic process (Nissen-Lie et al., 2010, 2013, 2017). Although seemingly paradoxical, the authors interpreted this finding by suggesting that a higher level of professional self-doubt is indicative of a tendency to be more open to feedback and reflective about one's professional practices (Nissen-Lie et al., 2017). Professional self-doubt

might serve as a motivator for therapists to reflect on their performance, which in turn may prompt them to seek guidance and/or alter their approach through ROM. Thus, a certain amount of professional self-doubt may be associated with an increased willingness to use client-rated feedback in a meaningful way.

Cultural humility is another potential moderator of ROM effectiveness. Research indicates there is variability within therapists' caseloads in terms of their effectiveness with clients with marginalized identities (Hayes et al., 2016). Yet, therapists tend to have difficulty accurately assessing the boundaries of their multicultural competence, which has prompted researchers to recommend that multicultural competence be determined by outcome measures (Imel et al., 2011). Therapists who are culturally humble might be more likely to view ROM as an unbiased indicator of their cultural competence and as a useful way to ensure the delivery of services that are culturally sensitive (Pinner & Kivlighan, 2018). More generally, researchers have also proposed that the characteristics necessary for the effective use of feedback seem to be encompassed within the broader concept of clinician humility. Previous authors have identified the following core features of general humility: (a) willingness and ability to accurately assess one's own personal characteristics and achievements, (b) a modest self-presentation, and (c) increased focus on others versus the self (Davis et al., 2011). Humility may play an important role in several aspects of ROM. For example, humility is needed to increase openness to feedback that some clients are NOT and be willing to adjust one's therapy approach.

RESEARCH SUMMARY AND FUTURE RESEARCH CONSIDERATIONS

Most of the research supports the use of ROM with a range of adult clients in individual psychotherapy, with some evidence that it is also beneficial in couples and group therapy formats. Yet, there is recent research to suggest that ROM may not work in certain settings and may be less effective than originally believed. The benefits

and potential limits of ROM merit further scrutiny, and yet it is important to consider these findings from multiple perspectives. Although we are admittedly biased, a more balanced critique is warranted given the number of positive findings. First, there seems to be a pattern in the studies that find benefit versus those that have not. Level of intentionality and intensity of ROM appear to matter. Lambert and colleagues demonstrated this with the inclusion of clinical support tools that increased benefit to their original ROM process (Lambert et al., 2018), as did Janse et al. (2020), whose findings indicated that frequency of ROM matters (every session versus every fifth session). All of the studies that did not find an effect for ROM seemed to lack the intensity/intentionality dimension in some manner, either via adherence or simply by not having enough sessions to evaluate the intervention adequately (Duncan & Sparks, 2019).

Second, a critique has been that ROM benefits are less impressive overall when an alternate outcome measure is used. We agree this must be considered carefully, and future research is clearly needed. Using the outcome measure that is part of the monitoring intervention could introduce demand characteristics and inflate scores. Yet, another consideration is that the measures continually used as part of treatment helped shape treatment and their subsequent outcomes. Perhaps the measure is a *more* accurate reflection of the client's experience and treatment outcome as well as *more* sensitive to change than symptom-based measures. Some evidence supports this possibility. For example, DeSantis et al. (2017) found the ORS to be more sensitive to patient distress and therefore identified more patients in primary care for behavioral health intervention than did the PHQ-9.

Future research should address this question by evaluating the level of correspondence between measures used as part of ROM and those used to evaluate the ultimate effectiveness of ROM systems on central client treatment outcomes. An example of this, Delgado et al. (2018) found that ROM showed benefit on a quality-of-life measure, but not symptom severity. More

studies like this are needed. Both our clinical and research experiences (Duncan et al., 2021) suggest that global improvements in functioning as measured by the ORS (including quality of life) are often more relevant to client treatment goals and precede symptom improvement. Malins et al. (2020) found that last-session ORS scores predicted multiple outcomes 12 months later, including symptom severity of anxiety. In addition, there are notable exceptions to the concerns. Brattland et al. (2018) and Duncan et al. (2021) found a feedback effect on the Basis-32 and PHQ-9, respectively, and several other studies found corroborating evidence on other variables, such as attendance, divorce rates, and masked clinician and observer ratings (Anker et al., 2009; Schuman et al., 2015; She et al., 2018). These studies cast considerable doubt on the demand characteristics hypothesis.

Even though debate persists about the benefits of ROM, the totality of the research supports its effectiveness with clients. Future research also needs to more fully consider the mechanisms through which ROM works and the conditions under which it works best, as opposed to only testing that it works in comparison to not using ROM or ROM-based feedback. The issue of measurement is a critical issue to address, and future research needs to move beyond the monomethod to evaluate outcome. Further, RCT studies that compare the clinical processes need to be conducted. For example, does the level of collaboration influence ROM outcomes? Lastly, more research is needed to evaluate ROM in different settings and with different populations. This includes more focus on clients of color and other marginalized, underrepresented populations to understand how ROM can be used in a culturally responsive manner.

CLINICAL IMPLICATIONS OF ROUTINE OUTCOME MONITORING

All seven ROM approaches briefly reviewed offer good choices for individuals, agencies, or graduate programs. All seven concur that there are three major clinical implications of ROM:

improving client care, improving supervision/training, and improving behavioral health policy.

Improving Care to Clients

As noted, there is compelling evidence (small-to-moderate effect sizes) that ROM improves outcomes and reduces dropouts compared with TAU. Lambert (2015) concluded, "The effects of these procedures are much larger than those achieved by providing the right treatment for the right disorder. Given the strength of research support it makes little sense to continue to offer routine care in the absence of effective feedback practices" (p. 388). Nevertheless, implementation lags far behind the science. A recent study of social workers, counselors, and marriage and family therapists ($n = 504$) indicated that only 13.9% of participants reported use of standardized progress measures (Jensen-Doss et al., 2018). When asked about how often they would like to administer these measures, nearly 25% of participants said they would like to gather frequent progress data. However, only 6.8% said they would prefer administering them every one to two sessions, and 45% said they would prefer to not gather any progress data. Thus, consistent with prior studies of psychologists (Ionita et al., 2020), these data indicate very low rates of ROM use by clinicians. But there is hope, and it comes with supervision and training.

Improving Supervision and Training

The use of ROM data in supervision has been suggested as a way of addressing the lack of focus on client outcome in both practice and research (Reese et al., 2009; Sparks et al., 2011; Worthen & Lambert, 2007). Lambert and Hawkins (2001) were the first to suggest that supervision could use outcome data as a means of shaping supervision time and facilitating both training and ensuring that clients were benefitting. Duncan and Reese (2015) highlighted several advantages of data-based supervision. Particularly for therapists early in training, outcome measures readily identify what is most salient to the client and helps frame the session. Beginning counselors also want to know if they are being helpful to

clients, and outcome data directly address this question. Without outcome feedback, trainees could complete their training without really having an answer. More troubling is a clinician may not have an answer over the course of an entire career!

From a supervisor perspective, using client outcome data, as noted by Lambert and Hawkins (2001), makes more efficient use of supervision time. Outcome data not only identifies clients who require more attention, but also grants a more realistic account of trainees' performance. Supervisors are often left to rely on the trainee's perspective, which is often fraught with wishful thinking (Walfish et al., 2012) or bias exacerbated by any evaluative context. Finally, Worthen and Lambert (2007) suggested that outcome data allow specific supervisory feedback that is value neutral given that it comes from the client. This subtle shift may seem more collaborative rather than evaluative, and permit feedback to be better heard.

Not much empirical evidence is available about supervision with ROM or supervision and outcome in general. Reese et al. (2009) assigned trainees ($n = 28$) to either a ROM condition (client feedback was used and the results were discussed with the supervisor) or a no-feedback condition. Trainees in both conditions demonstrated significant improvement in client outcomes (client sample, $n = 110$), but those in the feedback condition exhibited almost twice as much. The supervisees in the feedback condition also demonstrated more improvement across their caseloads from fall to spring semester. In a follow-up study, Grossl et al. (2014) isolated the influence of using client feedback data in supervision. In all, 44 trainees were randomly assigned either to a supervision condition in which client feedback data were discussed or to a supervision-as-usual condition. All trainees used feedback with their clients. No significant differences were found on client outcome, but trainees in the feedback supervision condition reported increased supervision satisfaction.

Duncan and Reese (2015) suggested additional supervisory processes based on ROM data and

Orlinsky and Rønnestad's (2005) extensive, ongoing longitudinal investigation of therapist development. Orlinsky and Rønnestad identified two types of therapist growth. First is the therapist's experience of *career development*, or improvement in clinical skills. Therapists want to believe that they are getting better over the course of their career. ROM provides an objective way of knowing whether career development is happening, as well as the impetus for the therapist to take charge of it. Supervision provides the structure and encouragement to monitor and accelerate supervisee development via a transparent discussion of therapist effectiveness.

The second and most powerful influence on development identified by Orlinsky and Rønnestad (2005) is therapists' sense of their *current growth*, which mainly arises from their experience with clients. Therapists truly believe that clients are the best teachers of psychotherapy. Here the supervisor asks about what has been learned from successful and unsuccessful clients, about anything that happened that was new or different, and about the supervisee's thoughts about their identity—helping the therapist to experience current growth, value the daily work with clients, and partake in the opportunities for development and replenishment they offer. Clients who are not benefiting provide the best opportunities for accelerating development and for encouraging supervisees to do things they have never done and embrace the uncertainty endemic to the work, as it is to life (Duncan, 2014).

Whereas the Jensen-Doss et al. (2018) and Ionita et al. (2020) studies paint a somewhat dismal picture of therapist use of ROM, a look at implementation in graduate programs portrays a sunnier outlook. Peterson and Fagan (2017) surveyed psychology training clinic directors about the use of ROM and reported that 67% indicated they were currently using some form of ROM in their clinics. Cooper et al. (2019) described the long-term process of implementing ROM in a graduate program. They ultimately achieved about 70% compliance with ROM. In tandem with utilizing brief measures and web-based technology, Cooper et al. reported that intensive, long-term

clinician training and support to be a critical factor affecting ROM implementation and adoption.

Brown et al. (2015) concluded:

Thus, we believe that the evidence requires the introduction of feedback informed treatment into all therapist training programs if they wish to claim that they are training effective therapists based on the evidence. Without this experience . . . , the new therapists will not be prepared to thrive in a world that demands accountability and evidence of effectiveness. Without ongoing performance feedback, therapists lack the information necessary to improve their results—or worse, they may simply remain ineffective or deteriorate. (p. 419)

Improving Policy

It is impossible to discuss ROM and large-scale data collection without touching briefly on accreditation, as well as public and private reimbursement for behavioral health services. First, all three behavioral health accreditation bodies in the United States—the Council on Accreditation (COA), the Commission on Accreditation of Rehabilitation Facilities (CARF), and the Joint Commission—now require some form of client-generated outcome management. In the public domain, accreditation is required for reimbursement, so the upcoming accreditation cycle visits will likely result in increased ROM implementation beyond that reported by Jensen-Doss et al. (2018).

Regarding reimbursement, ROM provides a direct way to administer what has been called pay for performance, or P4P. P4P started in health care and describes payment models that offer financial rewards to providers who achieve quality benchmarks using performance measures related to the structure, process, and outcome of providing services. The intentions are good here—P4P programs are designed to improve access, quality of care, consumer experience, provider

participation, and decrease health-care costs. For example, the Centers for Medicare and Medicaid Services recently added practicing psychologists to the Merit-based Incentive Payment System (Rousmaniere et al., 2020). This means that psychologists' reimbursements for Medicare services may be adjusted based on their performance, ranging from a bonus of 7% to a penalty of -7%. In addition to increased pay for services, referral steerage is another suggested incentive, with the idea being that the providers with demonstrated superior outcomes would be prioritized and receive more clients from reimbursement entities. The upside is summarized by Boswell et al. (2015):

The outcome report would provide options of at least three area clinicians who have documented superior outcomes in treating clients with similar issues. . . . Aggregate data would help therapists and clinics identify the areas where they have the greatest opportunity to improve outcomes through continuing education, supervision, and online trainings . . . providers who participate . . . should be paid at higher rates because they are delivering more value. (p. 429)

These issues are complex, and there is a downside. Provider profiling and incentive practices based on outcome may turn therapists even more against ROM and could perhaps encourage providers to “cheat the system” to ensure referrals and a competitive edge. Pay for *participation*, on the other hand, could incentivize the identification of clients at risk and create an infrastructure to truly improve the quality of care (Duncan, 2014).

CONCLUSION

To answer the question posed in the chapter title, the answer is *yes*—the preponderance of evidence supports the use of ROM in psychotherapy with adults. In fact, the empirical support for ROM has been encouraging enough that the American

Psychological Association (APA) Presidential Taskforce on Evidence-Based Practice (2006) recommended its use as a best practice. Moreover, research is evolving with more focus on understanding the mechanisms of change and expanding its use in different settings and with different client populations. More research is needed, but currently it seems that the intentionality of using ROM matters. An intentional, systematic approach should be used—ROM is more than simply the administration of measures. Another consideration is that clinicians select a system that is proactive rather than reactive. By this we mean using ROM measures consistently and recognizing that the magic is not the measures, but also what is done with them. But that is not to say that the measures do not matter. They need to be psychometrically sound, responsive to change, and have ecological validity—they should capture the client's experience of their well-being.

Beyond the research, we believe ROM promotes the right professional values. It is an ethical practice at the client, therapist, and system levels (Muir et al., 2019) that ensures that the client's perception of progress is front-and-center and holds both therapist and client accountable. It invites humility, both culturally and more generally, and promotes a sense of collaboration. We are excited about ROM's proliferation and for future research that will help highlight how to best use and implement ROM to improve clinical practice and training.

References

- Adelman, R. (2005). Reducing adolescent clients' anger in a residential substance abuse treatment facility. *Journal on Quality and Patient Safety*, 31, 325–327. [https://doi.org/10.1016/S1553-7250\(05\)31042-7](https://doi.org/10.1016/S1553-7250(05)31042-7)
- Anker, M. G., Duncan, B. L., & Sparks, J. A. (2009). Using client feedback to improve couple therapy outcomes: A randomized clinical trial in a naturalistic setting. *Journal of Consulting and Clinical Psychology*, 77(4), 693–704. <https://doi.org/10.1037/a0016062>
- APA Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist*, 61(4), 271–285. <https://doi.org/10.1037/0003-066X.61.4.271>
- Barkham, M., Mellor-Clark, J., & Stiles, W. B. (2015). A CORE approach to progress monitoring and feedback: Enhancing evidence and improving practice. *Psychotherapy*, 52(4), 402–411. <https://doi.org/10.1037/pst0000030>
- Barkham, M., Stiles, W. B., Connell, J., & Mellor-Clark, J. (2012). Psychological treatment outcomes in routine NHS services: What do we mean by treatment effectiveness? *Psychology and Psychotherapy*, 85(1), 1–16. <https://doi.org/10.1111/j.2044-8341.2011.02019.x>
- Bickman, L. (2008). A measurement feedback system (MFS) is necessary to improve mental health outcomes. *Journal of the American Academy of Child & Adolescent Psychiatry*, 47(10), 1114–1119. <https://doi.org/10.1097/CHI.0b013e3181825af8>
- Boswell, J. F., Kraus, D. R., Castonguay, L. G., & Youn, S. J. (2015). Treatment outcome package: Measuring and facilitating multidimensional change. *Psychotherapy*, 52(4), 422–431. <https://doi.org/10.1037/pst0000028>
- Bratland, H., Koksvik, J. M., Burkeland, O., Gråwe, R. W., Klöckner, C., Linaker, O. M., Ryum, T., Wampold, B., Lara-Cabrera, M. L., & Iversen, V. C. (2018). The effects of routine outcome monitoring (ROM) on therapy outcomes in the course of an implementation process: A randomized clinical trial. *Journal of Counseling Psychology*, 65(5), 641–652. <https://doi.org/10.1037/cou0000286>
- Brooks Holliday, S., Hepner, K. A., Farmer, C. M., Mahmud, A., Kimerling, R., Smith, B. N., & Rosen, C. (2021). Discussing measurement-based care with patients: An analysis of clinician-patient dyads. *Psychotherapy Research*, 31(2), 211–223. <https://doi.org/10.1080/10503307.2020.1776413>
- Brown, G. S., Simon, A., Cameron, J., & Minami, T. (2015). A collaborative outcome resource network (ACORN): Tools for increasing the value of psychotherapy. *Psychotherapy*, 52(4), 412–421. <https://doi.org/10.1037/pst0000033>
- Burlingame, G. M., Whitcomb, K. E., Woodland, S. C., Olsen, J. A., Beecher, M., & Gleave, R. (2018). The effects of relationship and progress feedback in group psychotherapy using the Group Questionnaire and Outcome Questionnaire-45: A randomized clinical trial. *Psychotherapy*, 55(2), 116–131. <https://doi.org/10.1037/pst0000133>
- Carlier, I. V., Meuldijk, D., Van Vliet, I. M., Van Fenema, E., Van der Wee, N. J., & Zitman, F. G. (2012). Routine outcome monitoring and feedback on physical or mental health status: Evidence and theory. *Journal of Evaluation in Clinical Practice*, 18(1), 104–110. <https://doi.org/10.1111/j.1365-2753.2010.01543.x>

- Castonguay, L. G., Locke, B. D., & Hayes, J. A. (2011). The center for collegiate mental health: An example of a practice-research network in university counseling centers. *Journal of College Student Psychotherapy, 25*(2), 105–119. <https://doi.org/10.1080/87568225.2011.556929>
- Chapman, C. L., Burlingame, G. M., Gleave, R., Rees, F., Beecher, M., & Porter, G. S. (2012). Clinical prediction in group psychotherapy. *Psychotherapy Research, 22*(6), 673–681. <https://doi.org/10.1080/10503307.2012.702512>
- Clark, D. M. (2011). Implementing NICE guidelines for the psychological treatment of depression and anxiety disorders: The IAPT experience. *International Review of Psychiatry, 23*(4), 318–327. <https://doi.org/10.3109/09540261.2011.606803>
- Constantino, M. J., Boswell, J. F., Coyne, A. E., Swales, T. P., & Kraus, D. R. (2021). Effect of matching therapists to patients vs assignment as usual on adult psychotherapy outcomes: A randomized clinical trial. *JAMA Psychiatry, 78*(9), 960–969. <https://doi.org/10.1001/jamapsychiatry.2021.1221>
- Cooper, L. D., Murphy, H. G., Delk, L. A., Fraire, M. G., Van Kirk, N., Sullivan, C. P., Waldron, J. C., Halliburton, A. E., Schiefelbein, F., & Gatto, A. (2019). Implementing routine outcome monitoring in a psychology training clinic: A case study of a process model. *Training and Education in Professional Psychology, 15*(2), 87–96. <https://doi.org/10.1037/tep0000298>
- Crawford, M. J., Thana, L., Farquharson, L., Palmer, L., Hancock, E., Bassett, P., Clarke, J., & Parry, G. D. (2016). Patient experience of negative effects of psychological treatment: Results of a national survey. *The British Journal of Psychiatry, 208*(3), 260–265. <https://doi.org/10.1192/bjp.bp.114.162628>
- Davidsen, A. H., Poulsen, S., Lindschou, J., Winkel, P., Trøndarson, M. F., Waadegaard, M., & Lau, M. (2017). Feedback in group psychotherapy for eating disorders: A randomized clinical trial. *Journal of Consulting and Clinical Psychology, 85*(5), 484–494. <https://doi.org/10.1037/ccp0000173>
- Davis, D. E., Hook, J. N., Worthington, E. L., Jr., van Tongeren, D. R., Gartner, A. L., Jennings, D. J., II, & Emmons, R. A. (2011). Relational humility: Conceptualizing and measuring humility as a personality judgment. *Journal of Personality Assessment, 93*, 225–234. <https://doi.org/10.1080/17439760.2018.1460686>
- de Jong, K., Conijn, J. M., Gallagher, R. A. V., Reshetnikova, A. S., Heij, 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*, 102002. <https://doi.org/10.1016/j.cpr.2021.102002>
- Delgado, J., de Jong, K., Lucock, M., Lutz, W., Rubel, J., Gilbody, S., Ali, S., Aguirre, E., Appleton, M., Nevin, J., O'Hayon, H., Patel, U., Sainy, A., Spencer, P., & McMillan, D. (2018). Feedback-informed treatment versus usual psychological treatment for depression and anxiety: A multisite, open-label, cluster randomised controlled trial. *The Lancet Psychiatry, 5*(7), 564–572. [https://doi.org/10.1016/S2215-0366\(18\)30162-7](https://doi.org/10.1016/S2215-0366(18)30162-7)
- Delgado, J., McMillan, D., Gilbody, S., de Jong, K., Lucock, M., Lutz, W., Rubel, J., Aguirre, E., & Ali, S. (2021). Cost-effectiveness of feedback-informed psychological treatment: Evidence from the IAPT-FIT trial. *Behaviour Research and Therapy, 142*, 103873. <https://doi.org/10.1016/j.brat.2021.103873>
- Delgado, J., Overend, K., Lucock, M., Groom, M., Kirby, N., McMillan, D., Gilbody, S., Lutz, W., Rubel, J. A., & de Jong, K. (2017). Improving the efficiency of psychological treatment using outcome feedback technology. *Behaviour Research and Therapy, 99*, 89–97. <https://doi.org/10.1016/j.brat.2017.09.011>
- DeSantis, B., Jackson, M. J., Duncan, B. L., & Reese, R. J. (2017). Casting a wider net in behavioral health screening in primary care: A preliminary study of the Outcome Rating Scale. *Primary Health Care Research & Development, 18*(2), 188–193. <https://doi.org/10.1017/S1463423616000311>
- Duncan, B., Miller, S., Sparks, J., Claud, D., Reynolds, L., Brown, J., & Johnson, L. D. (2003). The Session Rating Scale: Preliminary psychometric properties of a “working” alliance measure. *Journal of Brief Therapy, 3*, 3–12.
- Duncan, B., & Reese, R. J. (2013). Clinical and scientific considerations in progress monitoring: When is a measure too long? *Canadian Psychology, 54*(2), 135–137. <https://doi.org/10.1037/a0032362>
- Duncan, B., & Sparks, J. (2002). *Heroic clients, heroic agencies: Partners for change* (2nd ed.). ISTC Press.
- Duncan, B., & Sparks, J. (2019). The Partners for Change Outcome Management System: An integrated elearning manual for everything PCOMS. https://doi.org/10.1007/978-3-319-49425-8_896
- Duncan, B. L. (2014). *On becoming a better therapist: Evidence-based practice one client at a time* (2nd ed.). American Psychological Association. <https://doi.org/10.1037/14392-000>
- 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. L., Reese, R. J., Lengerich, A. J., DeSantis, B., Comeau, C. V., & Johnson-Esparza, Y. (2021). Measurement-based care in integrated health care: A randomized clinical trial. *Families, Systems & Health*, 39(2), 259–268. <https://doi.org/10.1037/fsh0000608>
- Flückiger, C., Del Re, A. C., Wampold, B. E., & Horvath, A. O. (2018). The alliance in adult psychotherapy: A meta-analytic synthesis. *Psychotherapy*, 55(4), 316–340. <https://doi.org/10.1037/pst0000172>
- Fortney, J. C., Unützer, J., Wrenn, G., Pyne, J. M., Smith, G. R., Schoenbaum, M., & Harbin, H. T. (2017). A tipping point for measurement-based care. *Psychiatric Services*, 68(2), 179–188. <https://doi.org/10.1176/appi.ps.201500439>
- Goodman, L. A., Liang, B., Helms, J. E., Latta, R. E., Sparks, E., & Weintraub, S. R. (2004). Training counseling psychologists as social justice agents: Feminist and multicultural principles in action. *The Counseling Psychologist*, 32(6), 793–836. <https://doi.org/10.1177/0011000004268802>
- Grossl, A. B., Reese, R. J., Norsworthy, L. A., & Hopkins, N. B. (2014). Client feedback data in supervision: Effects on supervision and outcome. *Training and Education in Professional Psychology*, 8(3), 182–188. <https://doi.org/10.1037/tep0000025>
- Halstead, J., Youn, S. J., & Armijo, I. (2013). Scientific and clinical considerations in progress monitoring: When is a brief measure too brief? *Canadian Psychology*, 54(1), 83–85. <https://doi.org/10.1037/a0031324>
- Hannan, C., Lambert, M. J., Harmon, C., Nielsen, S. L., Smart, D. W., Shimokawa, K., & Sutton, S. W. (2005). A lab test and algorithms for identifying clients at risk for treatment failure. *Journal of Clinical Psychology*, 61(2), 155–163. <https://doi.org/10.1002/jclp.20108>
- Hayes, J. A., McAleavey, A. A., Castonguay, L. G., & Locke, B. D. (2016). Psychotherapists' outcomes with White and racial/ethnic minority clients: First, the good news. *Journal of Counseling Psychology*, 63(3), 261–268. <https://doi.org/10.1037/cou0000098>
- Howard, K. I., Kopta, S. M., Krause, M. S., & Orlinsky, D. E. (1986). The dose-effect relationship in psychotherapy. *American Psychologist*, 41(2), 159–164. <https://doi.org/10.1037/0003-066X.41.2.159>
- Howard, K. I., Lueger, R. J., Maling, M. S., & Martinovich, Z. (1993). A phase model of psychotherapy outcome: Causal mediation of change. *Journal of Consulting and Clinical Psychology*, 61(4), 678–685. <https://doi.org/10.1037/0022-006X.61.4.678>
- Imel, Z. E., Baldwin, S., Atkins, D. C., Owen, J., Baardseth, T., & Wampold, B. E. (2011). Racial/ethnic disparities in therapist effectiveness: A conceptualization and initial study of cultural competence. *Journal of Counseling Psychology*, 58, 290–298. <https://doi.org/10.1037/a0023284>
- Ionita, G., Ciquier, G., & Fitzpatrick, M. (2020). Barriers and facilitators to the use of progress-monitoring measures in psychotherapy. *Canadian Psychology*, 61(3), 245–256. <https://doi.org/10.1037/cap0000205>
- Janse, P. D., de Jong, K., Veerkamp, C., van Dijk, M. K., Huischemaekers, G. J. M., & Verbraak, M. J. P. M. (2020). The effect of feedback-informed cognitive behavioral therapy on treatment outcome: A randomized controlled trial. *Journal of Consulting and Clinical Psychology*, 88(9), 818–828. <https://doi.org/10.1037/ccp0000549>
- Jensen-Doss, A., Haimes, E. M. B., Smith, A. M., Lyon, A. R., Lewis, C. C., Stanick, C. F., & Hawley, K. M. (2018). Monitoring treatment progress and providing feedback is viewed favorably but rarely used in practice. *Administration and Policy in Mental Health*, 45(1), 48–61. <https://doi.org/10.1007/s10488-016-0763-0>
- Kaiser, T., Schmutzhart, L., & Laireiter, A. R. (2018). Attitudes of Austrian psychotherapists towards process and outcome monitoring. *Administration and Policy in Mental Health and Mental Health Services Research*, 45(2), 765–779. <https://doi.org/10.1007/s10488-018-0862-1>
- Kearney, L. K., Wray, L. O., Dollar, K. M., & King, P. R. (2015). Establishing measurement-based care in integrated primary care: Monitoring clinical outcomes over time. *Journal of Clinical Psychology in Medical Settings*, 22(4), 213–227. <https://doi.org/10.1007/s10880-015-9443-6>
- Kellybrew-Miller, A. (2015). *The impact of systematic client feedback on client outcomes in a community mental health center* [Unpublished doctoral dissertation]. University of Central Arkansas.
- Kendrick, T., El-Gohary, M., Stuart, B., Gilbody, S., Churchill, R., Aiken, L., Bhattacharya, A., Gimson, A., Brütt, A. L., de Jong, K., & Moore, M. (2016). Routine use of patient reported outcome measures (PROMs) for improving treatment of common mental health disorders in adults. *Cochrane Database of Systematic Reviews*, 2016(7), CD011119. <https://doi.org/10.1002/14651858.CD011119.pub2>
- Kluger, A. N., & DeNisi, A. (1996). The effects of feedback interventions on performance: A historical review, a meta-analysis, and a preliminary feedback intervention theory. *Psychological Bulletin*, 119(2), 254–284. <https://doi.org/10.1037/0033-2909.119.2.254>

- Knaup, C., Koesters, M., Schoefer, D., Becker, T., & Puschner, B. (2009). Effect of feedback of treatment outcome in specialist mental healthcare: Meta-analysis. *The British Journal of Psychiatry*, *195*(1), 15–22. <https://doi.org/10.1192/bjp.bp.108.053967>
- Kopta, M., Owen, J., & Budge, S. (2015). Measuring psychotherapy outcomes with the Behavioral Health Measure-20: Efficient and comprehensive. *Psychotherapy*, *52*(4), 442–448. <https://doi.org/10.1037/ps0000035>
- Krägeloh, C. U., Czuba, K. J., Billington, D. R., Kersten, P., & Siegert, R. J. (2015). Using feedback from patient-reported outcome measures in mental health services: A scoping study and typology. *Psychiatric Services*, *66*(3), 224–241. <https://doi.org/10.1176/appi.ps.201400141>
- Kraus, D. R., Baxter, E. E., Alexander, P. C., & Bentley, J. H. (2015). The Treatment Outcome Package (TOP): A multi-dimensional level of care matrix for child welfare. *Children and Youth Services Review*, *57*, 171–178. <https://doi.org/10.1016/j.childyouth.2015.08.006>
- Kraus, D. R., Castonguay, L., Boswell, J. F., Nordberg, S. S., & Hayes, J. A. (2011). Therapist effectiveness: Implications for accountability and patient care. *Psychotherapy Research*, *21*(3), 267–276. <https://doi.org/10.1080/10503307.2011.563249>
- Kraus, D. R., & Castonguay, L. G. (2010). TOP: Development and use in naturalistic settings. In M. Barkham, G. Hardy, & J. Mellor-Clark (Eds.), *A CORE approach to delivering practice-based evidence in counseling and the psychological therapies* (pp. 155–174). Wiley Press.
- Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine*, *16*(9), 606–613. <https://doi.org/10.1046/j.1525-1497.2001.016009606.x>
- Kwan, B., Rickwood, D. J., & Brown, P. M. J. P. R. (2021). Factors affecting the implementation of an outcome measurement feedback system in youth mental health settings. *Psychotherapy Research*, *31*(2), 171–183. <https://doi.org/10.1080/10503307.2020.1829738>
- Lambert, M. J. (2015). Progress feedback and the OQ-system: The past and the future. *Psychotherapy*, *52*(4), 381–390. <https://doi.org/10.1037/ps0000027>
- Lambert, M. J., & Hawkins, E. J. (2001). Using information about patient progress in supervision: Are outcomes enhanced? *Australian Psychologist*, *36*(2), 131–138. <https://doi.org/10.1080/00050060108259645>
- Lambert, M. J., & Shimokawa, K. (2011). Collecting client feedback. *Psychotherapy*, *48*(1), 72–79. <https://doi.org/10.1037/a0022238>
- Lambert, M. J., Whipple, J. L., Hawkins, E. J., Vermeersch, D. A., Nielsen, S. L., & Smart, D. W. (2003). Is it time for clinicians to routinely track patient outcome? A meta-analysis. *Clinical Psychology: Science and Practice*, *10*(3), 288–301. <https://doi.org/10.1093/clipsy.bpg025>
- Lambert, M. J., Whipple, J. L., & Kleinstäuber, M. (2018). Collecting and delivering progress feedback: A meta-analysis of routine outcome monitoring. *Psychotherapy*, *55*(4), 520–537. <https://doi.org/10.1037/ps0000167>
- Lambert, M. J., Whipple, J. L., Smart, D. W., Vermeersch, D. A., Nielsen, S. L., & Hawkins, E. J. (2001). The effects of providing therapists with feedback on patient progress during psychotherapy: Are outcomes enhanced? *Psychotherapy Research*, *11*(1), 49–68. <https://doi.org/10.1080/713663852>
- Lester, M. C. (2012). *The effectiveness of client feedback measures with adolescents in an acute psychiatric inpatient setting* [Unpublished doctoral dissertation]. University of Central Arkansas.
- Malins, S., Moghaddam, N., Morriss, R., & Schröder, T. (2020). Extending the use of routine outcome monitoring: Predicting long-term outcomes in cognitive behavioral therapy for severe health anxiety. *Psychotherapy Research*, *30*(5), 662–674. <https://doi.org/10.1080/10503307.2019.1657250>
- McAleavey, A. A., & Moltu, C. (2021). Understanding routine outcome monitoring and clinical feedback in context: Introduction to the special section. *Psychotherapy Research*, *31*(2), 142–144. <https://doi.org/10.1080/10503307.2020.1866786>
- Mellor-Clark, J., Twigg, E., Farrell, E., & Kinder, A. (2013). Benchmarking key service quality indicators in UK employee assistance programme counselling: A CORE System data profile. *Counselling & Psychotherapy Research*, *13*(1), 14–23. <https://doi.org/10.1080/14733145.2012.728235>
- Mikeal, C. W., Gillaspay, J. A., Scoles, M. T., & Murphy, J. J. (2016). A dismantling study of the Partners for Change Outcome Management System. *Journal of Counseling Psychology*, *63*(6), 704–709. <https://doi.org/10.1037/cou0000168>
- 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.
- Muir, H. J., Coyne, A. E., Morrison, N. R., Boswell, J. F., & Constantino, M. J. (2019). Ethical implications of routine outcomes monitoring for patients, psychotherapists, and mental health care systems. *Psychotherapy*, *56*(4), 459–469. <https://doi.org/10.1037/ps0000246>

- Nissen-Lie, H. A., Monsen, J. T., & Rønnestad, M. H. (2010). Therapist predictors of early patient-rated working alliance: A multilevel approach. *Psychotherapy Research, 20*, 627–646. <https://doi.org/10.1080/10503307.2010.497633>
- Nissen-Lie, H. A., Monsen, J. T., Ulleberg, P., & Rønnestad, M. H. (2013). Psychotherapists' self-reports of their interpersonal functioning and difficulties in practice as predictors of patient outcome. *Psychotherapy Research, 23*, 86–104. <https://doi.org/10.1080/10503307.2012.735775>
- Nissen-Lie, H. A., Rønnestad, M. H., Høglend, P. A., Havik, O. E., Solbakken, O. A., Stiles, T. C., & Monsen, J. T. (2017). Love yourself as a person, doubt yourself as a therapist? *Clinical Psychology & Psychotherapy, 24*, 48–60. <https://doi.org/10.1002/cpp.1977>
- Orlinsky, D. E., & Rønnestad, M. H. (2005). *How psychotherapists develop: A study of therapeutic work and professional growth*. American Psychological Association. <https://doi.org/10.1037/11157-000>
- Østergård, O. K., Randa, H., & Hougaard, E. (2020). 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.org/10.1080/10503307.2018.1517949>
- Pejtersen, J. H., Viinholt, B. C. A., & Hansen, H. (2020). Feedback-informed treatment: A systematic review and meta-analysis of the partners for change outcome management system. *Journal of Counseling Psychology, 67*(6), 723–735. <https://doi.org/10.1037/cou0000420>
- Peterson, A. P., & Fagan, C. (2017). Training the next generation in routine outcome monitoring: Current practices in psychology training clinics. *Training and Education in Professional Psychology, 11*(3), 182–189. <https://doi.org/10.1037/tep0000148>
- Pieterse, A. L., Lee, M., Ritmeester, A., & Collins, N. M. (2013). Towards a model of self-awareness development for counseling and psychotherapy training. *Counselling Psychology Quarterly, 26*(2), 190–207. <https://doi.org/10.1080/09515070.2013.793451>
- Pinner, D. H., & Kivlighan, D. M., III. (2018). The ethical implications and utility of routine outcome monitoring in determining boundaries of competence in practice. *Professional Psychology: Research and Practice, 49*(4), 247–254. <https://doi.org/10.1037/pro0000203>
- Pinsof, W. M., Zinbarg, R. E., Shimokawa, K., Latta, T. A., Goldsmith, J. Z., Knobloch-Fedders, L. M., Chambers, A. L., & Lebow, J. L. (2015). Confirming, validating and norming the factor structure of Systemic Therapy Inventory of Change initial and intersession. *Family Process, 54*(3), 464–484. <https://doi.org/10.1111/famp.12159>
- Poston, J. M., & Hanson, W. E. (2010). Meta-analysis of psychological assessment as a therapeutic intervention. *Psychological Assessment, 22*(2), 203–212. <https://doi.org/10.1037/a0018679>
- Reese, R. J., Duncan, B. L., Bohanske, R. T., Owen, J. J., & Minami, T. (2014). Benchmarking outcomes in a public behavioral health setting: Feedback as a quality improvement strategy. *Journal of Consulting and Clinical Psychology, 82*(4), 731–742. <https://doi.org/10.1037/a0036915>
- Reese, R. J., Toland, M. D., Slone, N. C., & Norsworthy, L. A. (2010). Effect of client feedback on couple psychotherapy outcomes. *Psychotherapy, 47*(4), 616–630. <https://doi.org/10.1037/a0021182>
- Reese, R. J., Usher, E. L., Bowman, D. C., Norsworthy, L. A., Halstead, J. L., Rowlands, S. R., & Chisolm, R. R. (2009). Using client feedback in psychotherapy training: An analysis of its influence on supervision and counselor self-efficacy. *Training and Education in Professional Psychology, 3*(3), 157–168. <https://doi.org/10.1037/a0015673>
- Rise, M. B., Eriksen, L., Grimstad, H., & Steinsbekk, A. (2012). The short-term effect on alliance and satisfaction of using patient feedback scales in mental health out-patient treatment. A randomised controlled trial. *BMC Health Services Research, 12*(1), 348. <https://doi.org/10.1186/1472-6963-12-348>
- Rise, M. B., Eriksen, L., Grimstad, H., & Steinsbekk, A. (2016). The long-term effect on mental health symptoms and patient activation of using patient feedback scales in mental health out-patient treatment. A randomised controlled trial. *Patient Education and Counseling, 99*(1), 164–168. <https://doi.org/10.1016/j.pec.2015.07.016>
- Rousmaniere, T., Wright, C. V., Boswell, J., Constantino, M. J., Castonguay, L., McLeod, J., Pedulla, D., & Nordal, K. (2020). Keeping psychologists in the driver's seat: Four perspectives on quality improvement and clinical data registries. *Psychotherapy, 57*(4), 562–573. <https://doi.org/10.1037/psr0000227>
- Saxon, D., & Barkham, M. (2012). Patterns of therapist variability: Therapist effects and the contribution of patient severity and risk. *Journal of Consulting and Clinical Psychology, 80*(4), 535–546. <https://doi.org/10.1037/a0028898>
- Schuman, D. L., Slone, N. C., Reese, R. J., & Duncan, B. L. (2015). Efficacy of client feedback in group psychotherapy with soldiers referred for substance abuse treatment: Preliminary results with a

- minimal feedback intervention. *Psychotherapy Research*, 25, 396–407. <https://doi.org/10.1080/10503307.2014.900875>
- Scott, K., & Lewis, C. C. (2015). Using measurement-based care to enhance any treatment. *Cognitive and Behavioral Practice*, 22(1), 49–59. <https://doi.org/10.1016/j.cbpra.2014.01.010>
- She, Z., Duncan, B. L., Reese, R. J., Sun, Q., Shi, Y., Jiang, G., Wu, C., & Clements, A. L. (2018). Client feedback in China: A randomized clinical trial in a college counseling center. *Journal of Counseling Psychology*, 65(6), 727–737. <https://doi.org/10.1037/cou0000300>
- Shimokawa, K., Lambert, M. J., & Smart, D. W. (2010). Enhancing treatment outcome of patients at risk of treatment failure: Meta-analytic and mega-analytic review of a psychotherapy quality assurance system. *Journal of Consulting and Clinical Psychology*, 78(3), 298–311. <https://doi.org/10.1037/a0019247>
- Sparks, J., & Duncan, B. (2019). Progress research in couple and family therapy. In J. L. Lebow, A. L. Chambers, & D. C. Breunlin (Eds.), *Encyclopedia of couple and family therapy* (pp. 2355–2362). Springer. https://doi.org/10.1007/978-3-319-49425-8_156
- Sparks, J. A., Kessler, T. S., Adams, J. F., & Blumen, D. G. (2011). Teaching accountability: Using client feedback to train effective family therapists. *Journal of Marital and Family Therapy*, 37(4), 452–467. <https://doi.org/10.1111/j.1752-0606.2011.00224.x>
- Spitzer, R. L., Kroenke, K., Williams, J. B. W., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: The GAD-7. *Archives of Internal Medicine*, 166(10), 1092–1097. <https://doi.org/10.1001/archinte.166.10.1092>
- Stiles, W. B., Barkham, M., & Wheeler, S. (2015). Duration of psychological therapy: Relation to recovery and improvement rates in UK routine practice [corrected]. *The British Journal of Psychiatry*, 207(2), 115–122. <https://doi.org/10.1192/bjp.bp.114.145565>
- Sun, Q., Wu, C., Wang, C. D. C., Yu, L., She, Z., & Falkenström, F. (2021). Alliance-outcome relation and progress feedback: Secondary data analyses of a randomized clinical trial study in China. *Psychotherapy Research*, 31(2), 145–156. <https://doi.org/10.1080/10503307.2020.1772517>
- Swift, J. K., & Greenberg, R. P. (2012). Premature discontinuation in adult psychotherapy: A meta-analysis. *Journal of Consulting and Clinical Psychology*, 80(4), 547–559. <https://doi.org/10.1037/a0028226>
- van Oenen, F. J., Schipper, S., Van, R., Schoevers, R., Visch, I., Peen, J., & Dekker, J. (2016). Feedback-informed treatment in emergency psychiatry: A randomised controlled trial. *BMC Psychiatry*, 16(1), 110. <https://doi.org/10.1186/s12888-016-0811-z>
- Walsh, S., McAlister, B., O'Donnell, P., & Lambert, M. J. (2012). An investigation of self-assessment bias in mental health providers. *Psychological Reports*, 110(2), 639–644. <https://doi.org/10.2466/02.07.17.PRO.110.2.639-644>
- Wampold, B. E., & Imel, Z. E. (2015). *The great psychotherapy debate: The evidence for what makes psychotherapy work* (2nd ed.). Routledge/Taylor & Francis Group.
- Worthen, V. E., & Lambert, M. J. (2007). Outcome-oriented supervision: Advantages of adding systematic client tracking to supportive consultations. *Counselling & Psychotherapy Research*, 7(1), 48–53. <https://doi.org/10.1080/14733140601140873>
- Youn, S. J., Castonguay, L. G., Xiao, H., Janis, R., McAleavey, A. A., Lockard, A. J., Locke, B. D., & Hayes, J. A. (2015). The Counseling Center Assessment of Psychological Symptoms (CCAPS): Merging clinical practice, training, and research. *Psychotherapy*, 52(4), 432–441. <https://doi.org/10.1037/pst0000029>