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Progress Research in Couple and Family Therapy

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Synonyms

Client feedback; Practice-based evidence; Progress monitoring; Progress research; Routine outcome measurement; Systematic client feedback

Introduction

Progress feedback refers to the routine collection of client feedback in psychotherapy services to track client progress, identify at-risk clients, and facilitate adjustment of therapy to prevent premature dropout or negative outcome (Lambert 2015). While progress feedback systems have been extensively tested in individual psychotherapy, development of scientifically sound and viable feedback systems for systemic work is still in its early stages. This entry discusses the theoretical underpinnings of progress feedback and its relevance and applicability to couple and family practice.

Theoretical Context for Concept

Close to 60% of clients in routine care have poor outcomes compared with approximately 30–40% of clients in clinical trials (Hansen et al. 2002). Outcomes for children and youth appear more concerning, with 40–60% dropout rates and effect sizes near 0 in some studies (Nelson et al. 2013). Making matter worse, clinicians tend to be overly optimistic about their effectiveness and are unable to predict which clients are likely to fail (Hannan et al. 2005). Progress feedback arose out of a desire to improve outcomes in routine practice, especially in light of these findings.

Progress feedback capitalizes on the pioneering research of Ken Howard (Howard et al. 1986) as well as more recent investigations that have found that most clients respond to treatment early, within 6–8 sessions. These findings support early and continuous monitoring of client perceptions of progress to prevent premature dropout. Many progress feedback systems also monitor the therapeutic alliance, an extensively researched variable predictive of outcome (Norcross 2010). Typically, this involves the collection of clients' views of the alliance during treatment to address current or emerging ruptures that might undermine client engagement.

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Description

Determining whether a treatment is working requires more than clinician intuition or adherence to a preselected approach. Progress feedback aims to identify treatment failures before they occur, allowing time for clinicians to restore therapy to a positive trajectory. Michael Lambert, the pioneer of real-time progress feedback and creator of the most empirically validated method, the Outcome Questionnaire (OQ) System, proposes that any system should minimally include a reliable and valid measure of client change, a signal for notification of at-risk clients, and continuous monitoring (Lambert 2015). Barry Duncan, developer of the clinical process of the Partners for Change Outcome Management System (PCOMS; Duncan and Reese 2015), the first to include routine alliance feedback, emphasizes feasibility for every session implementation, client privilege, and collaborative interpretation of data with clients. William Pinsof developed the first progress feedback system specifically designed to monitor change and the alliance with couples and families from a multisystemic perspective, the Systemic Therapy Inventory of Change (STIC; Pinsof 2017). Despite variations in feedback protocols and empirical support, effective progress feedback systems facilitate the fit between the therapist's approach and a client's unique circumstances and preferences to increase the chance of a positive outcome.

Application of Concept in Couple and Family Therapy

Given its origins in psychology, progress feedback was developed with the individual client in mind. Feedback protocols and research with couples and families, not surprisingly, have lagged behind. While gathering, interpreting, and integrating feedback with more than one client in the room add complexity to the process, progress feedback has the potential to clarify, or even unify, the diverse views of multiple clients in systemic practice. Moreover, clinicians increasingly are interested in realizing the demonstrated benefits of progress monitoring in systemic psychotherapies (Sparks 2015).

To date, six empirically studied progress feedback systems are used in systemic therapy. The following describes processes and modes of measurement to assess and respond to client feedback emphasized by each protocol and summarizes relevant research for each.

STIC. The Systemic Therapy Inventory of Change (STIC; Pinsof et al. 2009) measures progress by analyzing clients' reports of individual, partner/couple, and family change as well as how change in one domain impacts others. STIC is integrative in that it assesses behavioral, cognitive, and emotional aspects of each systemic dimension as well as clients' reports on their families of origin. The system is designed to provide an initial client assessment specific enough to develop preliminary treatment strategies and to assess targeted change during the course of treatment.

The STIC System measures consist of (1) Initial STIC, (2) Intersession STIC, and (3) three alliance scales: Individual Therapy Alliance Scale, Couple Therapy Alliance Scale, and Family Therapy Alliance Scale. The Initial STIC assesses clients' beginning status along six dimensions: individual problems and strengths, family of origin, relationship with partner, family/household, child problems and strengths, and relationship with child. Each contains a number of subscales.

Clients fill out the appropriate form (Initial STIC at the first session; Intersession STIC, second session and beyond) online approximately 24 hours prior to their session. Since STIC views all therapy as multisystemic, clients fill out all non-alliance scales regardless of whether they are receiving individual, couple, or family treatment. The appropriate alliance scale is attached to the intersession scale and is also completed by clients. Results from the scales generate a feedback report. The feedback report informs the primary targets, or foci, of the therapy. Just prior to each session from the second session on, therapists receive the Intersession Confirmation Report which provides information on changes in client functioning (improved or deteriorated and change

in relation to the clinical cutoff) and the alliance (improved or deteriorated) since the last session. A case report generates more specific subscale information about change.

The feedback report was originally designed to inform clinicians but gradually began to be shared and discussed with clients. Throughout treatment, online technology allows clients to view graphic depictions (e.g., bars and graphs) of scored results as well as those of others in treatment with them. Given the access to all scores for clients in a couple or family, members of the system are made aware of differences in various relationship domains that then can facilitate useful therapeutic conversations.

With the exception of the family/household domain, the Initial STIC scale was found to have strong convergent validity with widely used, validated measures (Pinsof et al. 2009). A confirmatory factor analysis supported construct and factorial validity for the integrative alliance scales. Research is underway to examine whether the STIC can predict change trajectories on specific scales for certain types of clients (Pinsof 2017).

PCOMS. The Partners for Change Outcome Management System (PCOMS; Duncan 2014) was designed to make available a valid and feasible option for routine practice settings, including public behavioral health and multisystemic treatment. PCOMS values client voice and the creation of working partnerships with clients through collaborative interpretation of scores and construction of treatment goals and methods.

Four instruments comprise the basic PCOMS measurement set: (1) the Outcome Rating Scale (ORS), (2) the Session Rating Scale (SRS), (3) the Child Outcome Rating Scale (CORS), and (4) the Child Session Rating Scale (CSRS). The ORS and SRS are used with adults and adolescents, aged 13–17. Children aged 6–12 use the CORS and CSRS. Adult caregivers provide feedback for their child or adolescent on either the CORS or ORS, based on the child's age. All PCOMS instruments consist of four visual analog lines. Child versions have "smiley faces" at either ends to aid in comprehension.

The ORS and CORS, administered at the beginning of each therapy meeting, measure client perception of progress, while the SRS and CSRS, given at the end of the meeting, measure client perception of the therapeutic alliance. PCOMS instruments are brief, generally requiring no more than 3–5 min to administer, score, and discuss. The SRS and CSRS seek to ward off alliance ruptures or identify them early. All expressions of concern on the SRS or CSRS are welcomed as they give clinicians a chance to acknowledge alliance problems and communicate to clients their intention to address them.

With PCOMS, client involvement is routine and expected; scores are openly shared and discussed immediately after they are collected. This creates openings for therapeutic conversations and provides a common reference point for what clients want to achieve, whether they believe therapy is helping, and their preferences for help. Open-ended visual analog scales allow clients to rate their global levels of distress without the constraints of specific theory or therapist-derived content domains. Specifics of that distress unfold as clinicians invite clients to give meaning to their scores.

PCOMS' measures can be completed using paper and pencil or on iPads or tablets linked to a web-based system, Better Outcomes Now (BON) (https://betteroutcomesnow.com/#/). BON automatically displays graphs of clients' scores in relation to clinical cutoffs, expected treatment response (ETR), and clients' treatment trajectories compared with the ETR. Customized dashboards give clinicians and supervisors alerts for at-risk clients and provide an array of reports at clinician, program, and agency levels.

Despite its brevity, the ORS generates reliable and valid scores, comparing favorably with the Outcome Questionnaire 45.2 (OQ-45) as well as other longer measures. The CORS and ORS with adolescents also have demonstrated strong reliability and moderate concurrent validity when compared with the Youth Outcome Questionnaire (YOQ). Both the ORS and CORS distinguish clinical from nonclinical populations. Similarly, the SRS has demonstrated strong reliability and

moderate concurrent validity with longer alliance instruments.

Five randomized controlled trials (see Duncan and Reese 2015), conducted by the Heart and Soul of Change Project (https://heartandsoulofchange.com/), compared PCOMS with treatment as usual (TAU). Notably, two randomized controlled trials with couples indicate a significant advantage for PCOMS clients over TAU clients (nearly four times the rate of clinically significant change) and sustained improvement at 6-month follow-up for feedback clients, double that for TAU clients. Feedback couples were 46% less likely than TAU couples to be separated or divorced at follow-up. These findings are indicators of PCOMS efficacy in systemic practice, at least with couples. A cohort study involving youth in a primary school setting and their caretakers found that 88.7% of the youth using PCOMS during their school-based counseling rated themselves improved; 77.6% of their caregivers reported reliable change for their child. When researchers compared the youth scores on the Strengths and Difficulties Questionnaire (SDQ) with those from school-based counseling in the UK where PCOMS was not used, they found an almost twofold advantage for youth using PCOMS based on caretaker-completed SDQs, with a small but significant advantage for teacher-completed SDQs.

CFS. Contextualized Feedback Systems (CFS) is a web-based application, continuous quality improvement system designed for use in youth mental health treatment (Bickman et al. 2011). CFS provides computerized client, caregiver, and clinician feedback reports to clinicians, agency directors, supervisors, and administrators and an alert for youth at risk of treatment failure. CFS was designed to address the lack of an evidence-based, psychometrically sound client feedback systems for youth receiving routine mental health services in office-, home-, and community-based care (https://peabody.vanderbilt.edu/docs/pdf/cepi/ptpb_2nd_ed/PTPB_2010_Chapter15_CFS_031212.pdf).

CFS collects and analyzes youth, caregivers, and clinician feedback throughout treatment using the Peabody Treatment Progress Battery (PTPB). The PTPB consists of 11 measures that assess relevant dimensions of mental health outcomes and processes. In developing the PTPB, collaborators included a large, social services agency delivering counseling to youth and families in their homes. Since the first PTPB manual, additional refinements and testing were conducted, resulting in reductions in the length of most measures. In its current form, the PTPB is intended for use for youth aged 11–18 in varied service settings, including outpatient mental health, home-based, and foster care.

The first six measures of the PTPB assess traditional outcome indices including systems functioning, life satisfaction, caregiver strain, hope, and service satisfaction. The remaining five instruments assess process dimensions, including the alliance, treatment outcome expectations, youth counseling impact, motivation, and session report. Measures of the PTPB are administered with varying frequency and at different points during treatment, either at baseline, regularly during treatment, or at discharge; CFS measures are given at the end of a session and can be scored either electronically using iPads or tablets or by paper and pencil with data entered at a later time. Clinicians view all data on a dashboard, with critical information (e.g., at-risk alerts) highlighted. Quality of implementation is recorded and is available to clinicians, supervisors, and agency managers to assist with adherence and integration of data.

All PTPB measures have undergone extensive rounds of psychometric testing with findings of validity and reliability for all respondent versions. A large, multistate randomized controlled trial was implemented to determine if weekly feedback to practitioners in home-based mental health treatment for youth improved outcomes (Bickman et al. 2011). According to clinician, caregiver, and youth assessments, youth in the feedback group improved faster than youth in the no-feedback group. Frequency of clinician viewing of feedback was correlated with significant increases in effect size, based on clinician and youth assessment.

Another CFS randomized controlled trial was conducted at two geographically separated

outpatient sites of the same agency in the USA (Bickman et al. 2016). Higher implementation at one site resulted in greater improvement by youth. Implementation at the second site was extremely low, though implementation rate at the first site was only 34%. Researchers concluded that failure to adequately use the system rather than the system itself resulted in the lack of effect for that location and even a modest attempt to incorporate feedback can have positive results.

OQ System. The Outcome Questionnaire System (OQ System; Lambert and Shimokawa 2011) consists of ongoing measurement of adult client mental health functioning and additional assessments for problem solving in instances of clients not changing as expected. The primary instrument administered for adults is the Outcome Questionnaire 45.2 (OQ-45.2; http://www.oqmeasures.com/), a 45-item self-report measure designed to assess three primary domains of client functioning: (1) symptoms of psychological distress, (2) interpersonal difficulties, and (3) social role functioning. The Youth Outcome Questionnaire (YOQ) and its derivatives are modeled after the adult OQ 45.2. These permit the identification of not-on-track youth clients (Nelson et al. 2013) and thus facilitate early identification of treatment failure in family systems practice.

The OQ is meant to be administered prior to the first session and weekly thereafter but can be used at specified midpoints and at treatment termination. OQ-Analyst is available as a software and Internet-hosted application that allow clients to score the OQ from their homes via tablet, IPad, smartphone, or paper and pencil scores entered on these devices. Reports are generated for clinicians within seconds. OQ and ASC feedback reports include clients' progress, current distress level, and critical items, along with an alert for clients not-on-track (NOT). NOT clients trigger assessment (clinical support tools; CSTs) of the alliance, social supports, motivation for change, diagnostic formulation, and life events for not-on-track clients. The core of the CSTs, a 40-item self-report questionnaire, Assessment for Signal Clients (ASC), aids in problem solving with clients predicted to have a poor outcome.

The YOQ-30 is filled out by parents or guardians. Youth ages 12–18 can self-report using the YOQ-SR. The YOQ-30 consists of 30 Likert-type items comprising six subscales: *somatic*, *social isolation*, *aggression*, *conduct problems*, *hyperactivity/distractibility*, and *depression/anxiety*; the YOQ-SR maps the same domains. The instruments are applicable not only for collection of pre- and post-therapy data but routine assessment of child and youth progress. Therapists identify NOT children and youth via the OQ-Analyst, giving the opportunity for therapists to speak with child or youth and caregiver/s and adjust the direction of treatment accordingly.

Research indicates that the OQ-45.2 is widely considered the gold standard of sound psychometrics. Both the OQ-45.2 and the shorter OQ-30 have been found to be effective in identifying potential treatment failures (Lambert 2015). Studies indicate the YOQ has high levels of internal consistency and test-retest reliability and correlates highly with the well-known Child Behavior Checklist, while the YOQ-30's levels of reliability are adequate. Both instruments distinguish between clinical and nonclinical populations. Studies indicate moderate to good validity and reliability for the YOQ, and it has been found to accurately predict youth deteriorating in naturalistic services.

Regarding outcome research, a meta-analysis of six RCTs of the OQ System found that 5.5% of at-risk clients whose therapists received feedback deteriorated compared with 20.1% of at-risk clients in the no-feedback group (Shimokawa et al. 2010). Positive outcomes for the feedback group were more than double that of the control group (55.5% versus 22.3%). Since this meta-analysis, six additional studies have been published supporting previous findings and expanding the evidence base for the OQ System across treatment settings, client samples, and countries (Lambert 2015). In one large study examining change trajectories for outpatient youth aged 4–17, more frequent YOQ administrations resulted in faster rates of change (Nelson et al. 2013). Another study found that the YOQ-2.1 warning system identified 69% of deteriorators in a community

mental health system and 61% in a managed care setting (Warren et al. 2012).

CORE. Clinical Outcomes in Routine Evaluation (CORE) is a client feedback system designed to monitor change in psychological services (http://www.coreims.co.uk/). CORE aggregates feedback data at multiple levels – client, therapist, sessions, episodes within sessions, and overall treatment delivery. Multiple stakeholders, including clients, therapists, managers, policymakers, service designers, and researchers, can benefit from client-generated data (Barkham et al. 2015). CORE -PC and CORE-NET provide software and cloud-based systems (respectively) for administration and collation of CORE measures data.

The original CORE measure, Clinical Outcomes in Routine Evaluation-Outcome Measure (CORE-OM), is a pan-theoretical self-report instrument tapping key psychological domains of subjective well-being, problems, functioning, and risks. The Young Person's Clinical Outcomes in Routine Evaluation (YP-CORE) expands application of the CORE to youth and families (Twigg et al. 2009). This ten-item instrument measures psychological distress in young people aged 11–16. The YP-CORE was developed after extensive involvement with practitioners and youth to ensure its language and content fit its purposes and were understandable to its intended client age group.

Both full and shorter parallel versions of the CORE-OM distinguish reliably between clinical and nonclinical samples. The CORE-OM has high levels of reliability and correlates highly with the Beck Depression Inventory and the Structured Clinical Interview for the DSM, evidence of convergent validity. Evaluation of the YP-CORE indicated good psychometric properties and sensitivity to change.

Two forms are completed by practitioners pre- and post-therapy, the CORE Therapy Assessment Form and the CORE End of Therapy Form, respectively. The pre-therapy form includes client demographic and referral information and therapist assessment of the severity and duration of the presenting problem. Therapists report on length of treatment, whether termination was planned, and types of interventions used in the post-therapy form. YP-CORE and associated YP-Therapy Assessment Forms and YP-End of Therapy forms are available in the CORE Net system.

The client-report CORE System is completed minimally prior to a first and last session, though it can be used at every session. Some services decide to keep therapists and clients unaware of scores, whereas others choose to specifically use CORE data in therapy conversations. The Y-P Score similarly is used either for pre- or post-therapy evaluation or more frequently for ongoing therapy monitoring.

SCORE. SCORE (The Systemic CORE) measures (SCORE, 40; SCORE, 15; http://www.aft.org.uk/view/score.html) were developed to address the need for a valid means of evaluating outcome in systemic family and couple therapy in the UK (Stratton et al. 2010). Informed by theory, clinical experience, and research, SCORE collects and analyzes self-reports of various members of a system regarding their views of family or couple functioning. The cornerstone of SCORE is systemic theory; it aims to document system health and progress over the course of psychotherapy treatment.

While inspired by the development of CORE, SCORE creators set out to develop an entirely new instrument capable of measuring system functioning and indicating the types of changes expected from family intervention. SCORE attempts to balance sound psychometrics with therapeutic and multicultural applicability. SCORE-40, deemed too long to be viable in everyday practice, spurred the creation of a shortened version, SCORE-15 (Stratton et al. 2014). SCORE-15 involves three primary factors: (1) strengths and adaptability, (2) overwhelmed by difficulties, and (3) disrupted communication. SCORE-15 is used for family members ages 11 and over. Child SCORE, adapted for use in the 8–11 age group, is modeled after the SCORE-15 with modified language and color gradations linked to the Likert scales to increase understanding of the questions.

Studies indicate SCORE-15's adequate to high reliability and validity as well as sensitivity to change in a clinical population (Stratton et al.

2014). Service users aged 12 or over were asked to complete SCORE-15 at the start of the first and fourth sessions. High rates of completion (87% and 98% for each occasion, respectively) indicated acceptability of the instrument in family and couple clinical practice settings.

SCORE-15 is introduced at the beginning of the first session and is completed privately by all those age 12 and over. Children ages 8–11 complete the Child SCORE. Family members are instructed to decide who to include as "family." This respects that definitions of family vary according to different cultural and familial contexts. The therapist informs the family that the questionnaire is designed to help focus therapy initially and will be revisited periodically to see if change has occurred. Forms are done individually, but family members can then decide if they would like to discuss their responses. At the sixth meeting (or later), clients are asked to fill out the SCORE-15 again to assess change. Family members again decide if they want to keep their answers private or share them with other members of the family. At the final session, the same procedure is repeated.

Clinical Example

Progress feedback in systemic treatment has the potential to facilitate fruitful conversations, especially in clarifying and negotiating different perceptions of the problem, progress in resolving the problem, or views of the alliance among multiple members of a couple or family system (Sparks and Duncan 2018). The example below generalizes this potential in one instance involving 10-year-old Max, diagnosed with autism spectrum disorder, and his parents who sought counseling due to Max's unwillingness to sleep in his own bed and anxious "meltdowns" at school.

> Max's parents, Elsie and Scott, sat on either side of Max as the therapist logs in on her iPad at the start of the fifth session. After each client scores how they see Max doing, she shows the screen to each. The scores indicate that Elsie believes Max is stuck below his expected treatment response (ETR). Scott places his son's progress as exceeding the ETR by two points. Max is in between, with the family domain higher than the school domain. The counselor invites each to explain their scores. Elsie states that she is unhappy with the continuing bedtime struggle and believes Max needs to learn greater independence at school. Scott believes it is better to give in to Max at bedtime so he gets the sleep he needs to deal with his teachers' inappropriate expectations. Max says he sleeps fine and just wants his teachers to "stop bugging him."

Progress feedback in this example allowed the precise and early depiction of family members' positions related to their presenting concern. Family members' different views of progress reflect such systemic variables as closeness/distance, hierarchy, and coalitions. The counselor requested a meeting with the parents for the next session where she invited Elsie and Scott to talk about their hopes and fears for their son. The ensuing conversation led to a plan – both agreed to hold firm with Max's independent sleep for at least two nights a week as a start and to encourage him to wait alone outside after school for his pickup rather than in the classroom. All agreed that, at the next session, Max, his parents, and the counselor would devise effective calming strategies for Max and ways to involve school personnel to support him with these.

Over several more sessions, family members' scores reached greater convergence and indicated an on-track trajectory. Family members were empowered to see their progress and to know that their voices mattered. Alliance scores remained strong throughout treatment (except when Max reminded the counselor that they had not played his favorite game). Different views of progress have implications for alliance scores, and knowing early the parents' different levels of satisfaction with progress allowed the counselor to adjust her work, acknowledging and working with those differences.

Routine client feedback that informs treatment has been the rationale for creation of progress monitoring systems. The goal has always been to improve outcomes by facilitating clinician decision-making in accord with regularly obtained client feedback. Particularly pertinent to multiclient treatment are concerns of feasibility. New technologies have streamlined administration of feedback measures and interpretation of

data, enabling timely alerts for deteriorating clients. Still, considerable variation exists in feasibility, frequency of feedback collection, and how feedback informs treatment. Variation also exists regarding the empirical support for each system with only two of the above (OQ Systems and PCOMS) designated as evidence-based practices. Despite these differences, systemic progress feedback is gaining a solid presence in varied treatment settings across the globe to ensure quality and effective services to children, families, and couples.

Cross-References

- SCORE
- Systemic Therapy Inventory of Change
- The Partners for Change Outcome Management System

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