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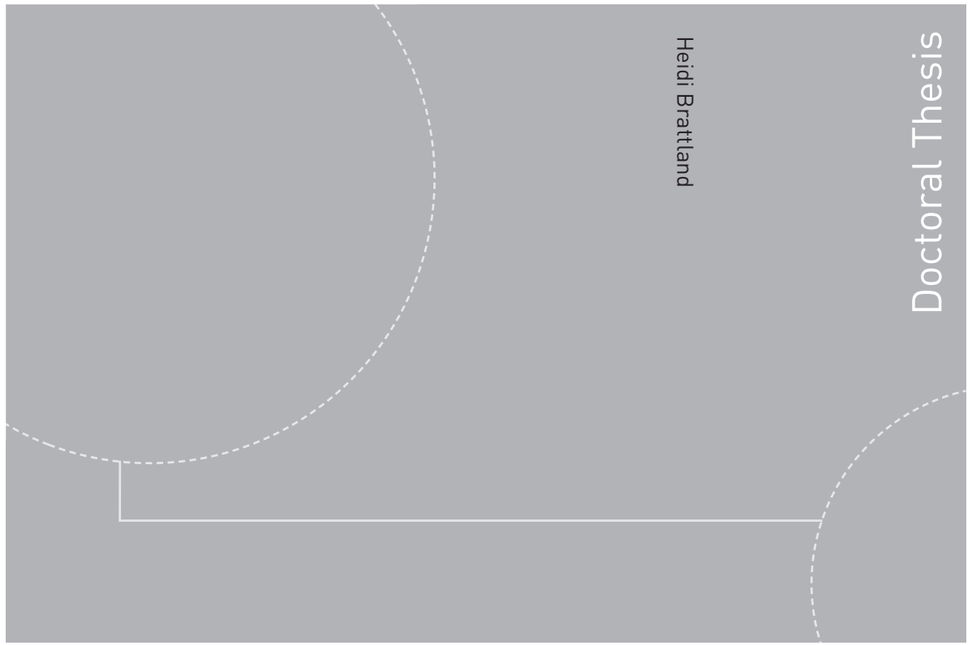

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A randomized clinical trial and a qualitative study at a hospital mental health center

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Thesis for the degree of Philosophiae Doctor

Trondheim, November 2018

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Norsk sammendrag

For hvem, når, og hvordan forbedrer tilbakemeldings-verktøy behandlingsutfall? En randomisert kontrollert og en kvalitativ studie på et distrikstpsykiatisk senter

Tilbakemeldings-verktøy, som Klient- og Resultatstyrt behandling eller Feedback-Informerte Tjenester (KOR/FIT), skal gjøre det lettere å følge med på hvordan det går med pasienter som er i samtalebehandling for psykiske lidelser. Dermed kan behandlingen tilpasses underveis, slik at pasienten får nytte av den. Det er det for stor og økende interesse for slike verktøy. Resultatene fra tidligere forskning har imidlertid vært blandede.

Formålet med denne avhandlingen var å undersøke hvorvidt systematiske tilbakemeldinger forbedrer behandlingen i spesialisthelsetjenesten. I tillegg utforsket vi noen faktorer som kan påvirke og forklare effekten av slike verktøy.

Studie 1 var en randomisert kontrollert studie der vi sammenlignet behandling med og uten KOR/FIT. Vi fant at flere pasienter fikk nytte av behandlingen når de brukte tilbakemeldings-verktøy. Dette gjaldt uavhengig av hvor dårlig pasientene var ved oppstart, og hvem behandleren var. Tilbakemeldings-verktøyet var mer virksomt mot slutten av en fireårig implementeringsperiode, enn det var i begynnelsen. Noe av effekten av verktøyet kunne forklares av at det hadde en positiv virkning på pasientenes opplevelse av arbeidsalliansen med sine behandlere.

Studie 2 var en kvalitativ undersøkelse av terapeuters erfaringer med å motta negative tilbakemeldinger fra pasienter. Resultatene tyder på at det kan være utfordrende og komplekst å forholde seg til misfornøyde pasienter, men at konkrete og direkte tilbakemeldinger gir behandlerne en mulighet til å endre sin atferd. Terapeutens forståelse og emosjonelle reaksjon på tilbakemeldingen, strategien deres i møtet med pasienten, og refleksjonene de gjorde seg i etterkant så ut til å påvirke hvorvidt de greide å forbedre den påfølgende terapiprosessen og/eller lære noe av tilbakemeldingene.

Avhandlingen bidrar til å nyansere vår forståelse av når, for hvem og hvordan tilbakemeldings-verktøy forbedrer behandlingsutfall. Denne kunnskapen kan brukes til å forbedre den kliniske bruken av slike verktøy, slik at flere pasienter får nytte av dem. Funnene tyder på at implementering av tilbakemeldings-verktøy kan forbedre behandling i spesialisthelsetjenesten. Det kan imidlertid kreve systematisk innsats over tid å oppnå denne effekten, og implementeringsarbeid, som opplæring og veiledning i bruken av tilbakemeldingsverktøy, bør prioriteres. Behandlere kan med fordel bruke slike verktøy til å få konkrete og direkte tilbakemeldinger om hvordan pasienten opplever behandlingsprosessen, og å jobbe aktivt med å utvikle en god arbeidsallianse.

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Veiledere: Professor Valentina Iversen og førsteamanuensis Truls Ryum

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LIST OF PAPERS

Paper I: Brattland, H., Koksvik, J. M., Burkeland, O., Gråwe, R. W., Klöckner, C., Linaker, O. M., Ryum, T., Wampold, B., Lara-Cabrera, M. L. & Iversen, V. (2018, In press). 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,* DOI: 10.1037/cou0000286

Paper II: Brattland, H., Koksvik, J. M., Burkeland, O., Klöckner, C., Lara-Cabrera, M. L., Miller, S. D., Wampold, B., Ryum, T., & Iversen, V. C. (2018). Does the alliance mediate the effects of Routine Outcome Monitoring (ROM)? A randomized clinical trial. (Submitted, April 18, 2018)

Paper III: Brattland, H., Høiseth, J. R., Burkeland, O., Inderhaug, T. S., Binder, P. E. & Iversen, V. (2016). Learning from clients: A qualitative investigation of psychotherapists' reactions to negative verbal feedback. *Psychotherapy research,* Advance online publication. DOI: 10.1080/10503307.2016.1246768

ACRONYMS AND ABBREVIATIONS

ASC	Assessment of Signal Cases (Lambert et al., 2007)
CI	Confidence Interval
CrI	Credibility Interval
CST	Clinical Support Tool (Lambert et al., 2007)
CQR	Consensual Qualitative Research (Hill, 2012)
d	Cohen's *d* effect size (e.g., estimate/standard deviation)
ETR	Expected Treatment Response; The rate at which clients, based on their initial scores and norm data, are expected to change in therapy
MLM	Multi-level model
NOT	Not On Track; not progressing at the expected rate in treatment
ORS	The Outcome Rating Scale (Miller, Duncan, Brown, Sparks, & Claud, 2003)
OR	Odds Ratio
OT	On Track; scoring at or above the expected treatment response
OQ	The Outcome Questionnaire system (Lambert, 2004)
PCOMS	The Partners for Change Outcome Monitoring System (Miller, Duncan, Sorrell, & Brown, 2005)
ROM	Routine Outcome Monitoring, sometimes referred to as client feedback systems, Patient-Reported Outcome Measures (PROMs), and Feedback-Informed Treatment (FIT)
SD	Standard Deviation
SRS	the Session Rating Scale (Duncan et al., 2003)
TAU	Treatment as Usual; control condition

DEFINITIONS

Alliance rupture	Strains or breakdowns in the collaborative working relationship in therapy (Safran & Muran, 2000)
Attribution	Understanding of the causality of a behavior or situation (e.g., internal attribution: caused by something within a person; external attribution: caused by external events)
Common factors	The higher-order mechanisms of change that the specific actions and techniques of the diverse therapy models are theorized to work through (Wampold & Imel, 2015)
Feedback	"a response to an action that shapes or adjusts that action in subsequent performance" (Claiborn & Goodyear, 2005, p. 209)
Feedback culture	Organizational culture in which feedback is valued and used to foster growth
Working alliance	The degree to which the therapy dyad is engaged in collaborative, purposeful work (Bordin, 1979; Hatcher & Barends, 2006)

SUMMARY

Background

Not all clients benefit from mental health treatment. Routine Outcome Monitoring (ROM) interventions, such as the Partners for Change Outcome Management System (PCOMS), attempt to solve this problem. Regularly administered, client-reported questionnaires help therapists monitor their clients' responses to treatment and continually adjust their approach to avoid negative treatment outcomes.

There is considerable interest in the use of ROM in Norway and internationally. However, previous research into the effect of ROM has produced mixed findings. Moreover, little is known about mechanisms of change inherent in ROM. Understanding under what circumstances, for whom, and how ROM improves outcomes could help improve the clinical implementation of these tools and thus, maximize their benefits.

This thesis investigated the effect of ROM in a hospital mental health care setting in Norway. A principal aim was to explore some variables that could influence and explain ROM's effect on outcomes. This was done through, first, investigating the main effect of ROM on treatment outcomes; second, exploring potential moderators to ROM's effect; third, exploring if ROM's effect was mediated by the alliance; and forth, exploring how therapists respond to negative feedback, and under what circumstances they learn from their clients' communication of dissatisfaction.

Study 1 (Papers I and II)

Methods. In a randomized clinical trial, treatment with the ROM system PCOMS was compared to treatment as usual (TAU). The sample consisted of 170 clients referred for individual outpatient treatment at a hospital mental health center, and 20 therapists employed at the center. Treatment outcomes and the working alliance were assessed using independent measures (i.e. other than the PCOMS' measures of wellbeing and alliance).

Results. In Paper I, a positive of ROM on treatment outcomes was established. Compared to TAU, clients in the ROM condition were 2.5 times more likely to experience a reliable improvement in their symptom and functioning. Controlled for initial impairment and therapist variability, the effect size of ROM over TAU was small ($d = 0.26$). Clients distress levels at intake did not influence ROM's effect, and therapists did not differ in the impact of ROM on their outcomes. ROM became increasingly more effective over the four-year

duration of the trial, so that clients receiving treatment towards the end of an extensive implementation period benefitted more from the intervention than those treated earlier.

In Paper II, we found that clients receiving treatment with ROM experienced more alliance improvement from session one to two months' treatment than those in TAU, and that improved alliances in the ROM condition explained 23% of the positive impact of ROM on treatment outcomes. Thus, consistent with a theory of alliance as one of the effective elements within ROM, the alliance was shown to mediate ROM's effect on outcomes.

Study 2 (Paper III)

Methods. Using a qualitative research methodology, we analyzed written descriptions from 18 experienced therapists of situations in which clients had expressed dissatisfaction with therapy.

Results. In Paper III, we found that interacting with dissatisfied clients can be challenging. Learning, as indicated by behavior change in the therapists, was typical in cases in which the feedback was specific and communicated face to face. Therapists were able to improve the subsequent therapy process when they focused on the client's contribution to the alliance problems while at the same time consciously regulating their own negative emotions, and engaged in a flexible negotiation with the client. Learning that extended beyond that particular therapy was described in cases in which the therapists were unsuccessful in improving the therapeutic relationship with that client, but reflected on their own contribution to the situation in retrospect, and tried out new ideas about what they could do differently with new clients. Possibly, this was motivated by lingering feelings of shame or guilt.

Conclusions

The thesis demonstrates that ROM can improve therapy outcomes in a hospital mental health care setting treating a severely impaired population. However, ROM may not be as effective at the beginning of an implementation period as later on and consequently, implementation efforts such as training and supervision of therapists should be prioritized. It might be advantageous for therapists to use ROM measures to obtain specific feedback about their client's experience of the therapy process, and work with this information to develop a strong working alliance. When training and supervising therapists in the use of ROM, it may be helpful to focus on therapists' immediate emotional reactions to negative feedback, as well as on the importance of post-event reflection on the therapist's own role in the situation.

1. INTRODUCTION

1.1. ROUTINE OUTCOME MONITORING (ROM)

Routine Outcome Monitoring (ROM) is a family of interventions developed to improve the quality of mental health treatment. Through the use of self-report measures, ROM systems track clients' responses to treatment throughout therapy and provide therapists with ongoing feedback about how the treatment is progressing (Howard, Moras, Brill, Martinovich, & Lutz, 1996; Lambert, 2007; Wampold, 2015). The content of this feedback is known predictors for therapy outcomes, particularly whether the client is changing at a rate typical for those that benefit from therapy (e.g., early in therapy) (Baldwin, Berkeljon, Atkins, Olsen, & Nielsen, 2009; Barkham et al., 2006; Hansen & Lambert, 2003; Hansen, Lambert, & Forman, 2002; Howard, Kopta, Krause, & Orlinsky, 1986; Stulz, Lutz, Leach, Lucock, & Barkham, 2007).

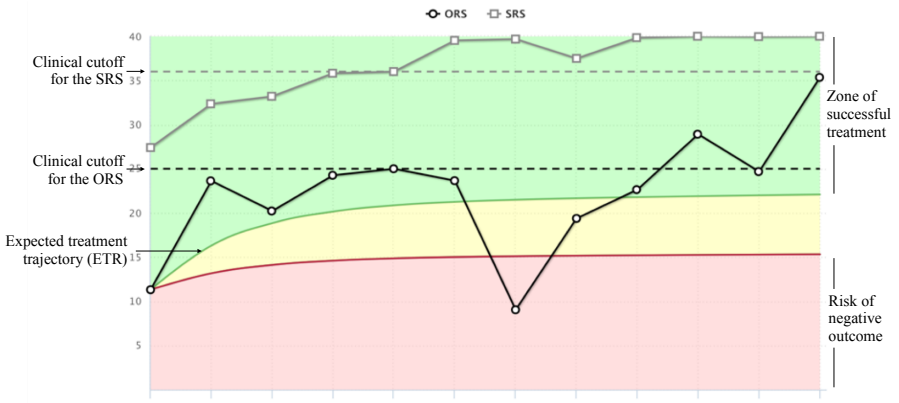
The rationale for the use of ROM is as follows: Although psychotherapy is an effective form of treatment (Hansen et al., 2002; Lambert & Ogles, 2004; Wampold & Imel, 2015), there is room for improvement. It has been reported that less than 50% of clients in routine outpatient psychotherapy practice improve, and about 5-10% deteriorate (Hansen & Lambert, 2003; Hansen et al., 2002; Lambert, 2010; Lambert & Ogles, 2004; Mohr, 1995). Therapists may have difficulties detecting lack of progress (Hatfield, McCullough, Frantz, & Krieger, 2010) and predicting negative treatment outcomes (Hannan et al., 2005), and this hampers their ability to prevent treatment failures. Thus, ROM systems are designed to supplement therapists' clinical judgement. There are several added benefits to the routine use of measurement systems, including the provision of practice-based evidence that can help expand our understanding of psychotherapy process (Holmqvist, Philips, & Barkham, 2015).

Several different ROM systems exist. Most research has focused on the Outcome Questionnaire (OQ) system (Lambert, 2004) or the Partners for Change Outcome Management System (PCOMS) (Miller et al., 2005). The latter was used in the research for the present thesis.

1.1.1 The Partners for Change Outcome Management System (PCOMS)

The use of PCOMS is described in *the International Center for Clinical Excellence's Manuals on Feedback Informed Treatment* (Bertolini & Miller, 2012). The intervention consists of two brief questionnaires, the Outcome Rating Scale (ORS; Miller et al., 2003) and the Session Rating Scale (SRS; Duncan et al., 2003). Therapists administer the ORS at the onset of each treatment session, and use the scores to track clients' current level of mental wellbeing and make sure that treatment is progressing as expected. The SRS is administered towards the end of every treatment session, and used to make sure that the therapy process and working alliance is on track. Often, these measures are administered using some computer software (e.g., www.fit-outcomes.com) that displays session-by-session scores in graphs, compares scores to normative trajectories of change, and provide warning signals if the current ORS or SRS score indicate lack of progress in therapy or problems in the working alliance. See Figure 1 for an example of a software-generated graph depicting the treatment progress and process of a client with a depressive disorder.

Figure 1. Example of PCOMS graph.



The PCOMS shares with other ROM systems the session-by-session measuring of symptoms and functioning, the use of algorithms to estimate expected treatment trajectories, and norm data derived parameters for clinically significant and reliable change. Some of the defining features of PCOMS relative to other ROM systems, are: (1) its brevity, with only four items in each of the two questionnaires; (2) its administration within the therapy session so that both therapist and client immediately have access to and can discuss the feedback from the questionnaires; (3) its use of an alliance measure at the end of every session.

In Norway, the PCOMS is recommended in the Government's Strategy for mental health (Helse- og Omsorgsdepartementet, 2017) as well as in the Department of Health's Guidelines for Local Mental Health and Substance Abuse Work with Adults (Helsedirektoratet, 2014) and the Guidelines for the Treatment and Rehabilitation of Substance Abuse Problems (Helsedirektoratet, 2017).

1.2 THE EFFECT OF ROM ON TREATMENT OUTCOMES

1.2.1 Meta-analyses

In addition to several reviews (e.g., Carlier et al., 2012; Davidson, Perry, & Bell, 2015; Gondek, Edbrooke-Childs, Fink, Deighton, & Wolpert, 2016; Krägeloh, Czuba, Billington, Kersten, & Siegert, 2015; Lambert, 2015), five meta-analyses of ROM studies have been published to date. Three of these were conducted by the research group that developed the OQ system. Lambert et al. (2003) included three OQ studies in their meta-analysis, Shimokawa, Lambert, and Smart (2010), six, and Lambert and Shimokawa (2011), six OQ studies and three PCOMS studies. Medium effect sizes in favor of OQ were reported for Not On Track (NOT; clients not progressing in treatment at the expected rate) clients in these three meta-analyses, ranging from Hedge's *g* (which is interpreted like Cohen's *d*) = 0.28 to 0.44. The effect size *g* for PCOMS was found to be 0.48. These three meta-analyses included relatively few studies, and most of them were conducted in university settings and by the same research group. Consequently, the results are not necessarily generalizable to all settings in which psychotherapy is provided.

A forth meta-analysis (Knaup, Koesters, Schoefer, Becker, & Puschner, 2009), conducted by an independent research group and including 12 studies, reported a substantially lower effect size estimate for ROM; $d = .10$ in short-term therapy and -.06 for long-term therapy. Here however, studies were very heterogeneous. Only tree studies investigated session-by-session progress measures in mental health treatment settings with a randomized controlled design and thus, the conclusions may not be relevant to the use of ROM in psychotherapy.

The fifth meta-analysis (Kendrick et al., 2016) was published in the Cochrane Library and included 17 studies where ROM was used in the treatment of common mental health disorders (i.e., studies in which the majority of clients were suffering from severe psychopathology were excluded). The authors found no evidence for an overall difference in

mean improvement in symptom scores. Moreover, the quality of the evidence was assessed to be low to average, with the main sources of bias being inadequate blinding of assessors and high attrition rates. The authors concluded that there was insufficient evidence in support of ROM in the treatment of common mental health disorders.

The body of ROM literature is complex and continues to grow. In the following, existing literature will be reviewed with an emphasis on primary studies investigating the effects of the PCOMS ROM system on symptoms of mental illness, psychosocial functioning, or psychological distress in the psychological treatment of adults in mental health treatment settings, including those serving psychiatric populations.

1.2.2 Primary studies

There are 11 published controlled trials of the PCOMS. These are summarized in Table 1. Ten were randomized controlled and one (Janse, De Jong, Van Dijk, Hutschemaekers, & Verbraak, 2017), a longitudinal study with a non-equivalent control group design. A variety of treatment formats and settings are represented. Seven studies reported superior overall treatment outcomes for ROM, with effect sizes ranging from $d = 0.28$ to 0.54. Two studies (Janse et al., 2017; Murphy, Rashleigh, & Timulak, 2012) found a selective effect of ROM on clients with mood disorders and anxiety disorders, respectively. Three studies (Davidsen et al., 2017; Rise, Eriksen, Grimstad, & Steinsbekk, 2016; van Oenen et al., 2016) reported no added benefits for ROM on any outcomes. In the latter (van Oenen et al., 2016) there were indications of adverse effects of ROM at six weeks' treatment although outcomes were the same in the ROM and TAU condition after 12 weeks.

The same variability in findings is present in research investigating other ROM systems. Some RCTs have reported superior overall effects of ROM to TAU (e.g., Amble, Gude, Stubdal, Andersen, & Wampold, 2015; Bickman, Kelley, Breda, de Andrade, & Riemer, 2011; Gibbons et al., 2015; Hawkins, Lambert, Vermeersch, Slade, & Tuttle, 2004; Simon et al., 2013), some have found a selective effect of ROM for some clients or therapists (e.g., de Jong et al., 2014; de Jong, van Sluis, Nugter, Heiser, & Spinhoven, 2012; Lambert et al., 2001; Probst et al., 2013; Schiefele et al., 2017; Simon, Lambert, Harris, Busath, & Vazquez, 2012; Whipple et al., 2003), some have reported null findings (Hansson, Rundberg, Österling, Öjehagen, & Berglund, 2013; Puschner, Schöfer, Knaup, & Becker, 2009), and some, adverse effects of ROM for some groups of clients or for some therapists (e.g., de Jong, Segaar, Ingenhoven, van Busschbach, & Timman, 2017; de Jong et al., 2012; Errázuriz & Zilcha-Mano, 2018).

Table 1. Overview of PCOMS trials published to date.

Reference	Design	*N*	Treatment format and setting	Outcome measure	Overall effect of ROM	Other outcomes
Anker et al. (2009)	RCT	410	Outpatient couple, community family counseling, Norway	ORS	Yes, $d = 0.50$	6-months follow-up: ROM > TAU Marital status: ROM > TAU NOT clients: ROM > TAU
Davidsen et al. (2017)	RCT	159	Outpatient group, psychotherapy center, Denmark	EDE	No	Attendance, psychological symptoms, functional impairment, self-harm: ROM = TAU NOT clients: ROM = TAU First 9 months of trial = Last 9 months of trial
Janse et al. (2016)	Quasi-experi-mental	1006	Outpatient individual, mental health organization, Netherlands	SCL-90	No	Mood disorders: ROM > TAU Anxiety, somatoform, and adjustment disorders: ROM = TAU ORS and SRS: ROM > TAU Number of sessions: ROM > TAU Dropout: ROM = TAU
Murphy et al. (2012)	RCT	110	Outpatient individual, university counseling service, Ireland	ORS	No	Anxiety disorders: ROM > TAU Treatment length: ROM = TAU
Reese et al. (2009a)	RCT	74	Outpatient individual, university counseling center, USA	ORS	Yes, $d = 0.54$	Number of sessions: ROM = TAU
Reese et al. (2009b)	RCT	74	Outpatient individual, graduate training clinic, USA	ORS	Yes, $d = 0.49$	Number of sessions: ROM = TAU Rate of change: ROM > TAU

Reference	Design	N	Treatment format and setting	Outcome measure	Overall effect of ROM	Other outcomes
Reese et al. (2010)	RCT	92	Outpatient couple, graduate training clinic, USA	ORS	Yes, $d = 0.48$	Rate of change: ROM > TAU
Rise et al. (2012, 2016)	RCT	75	Outpatient individual, hospital mental health center, Norway	BASIS-32	No	Patient activation, alliance, treatment satisfaction: ROM = TAU
Schuman et al. (2015)	RCT	263	Outpatient group, army substance abuse program, USA	ORS	Yes, $d = 0.28$	Retention: ROM > TAU
Slone et al. (2015)	RCT	84	Outpatient group, university treatment center, USA	ORS	Yes, $d = 0.41$	Number of sessions: ROM > TAU
Van Oenen et al. (2016)	RCT	287	Outpatient individual, psychiatric emergency center, Netherlands	BSI OQ-45	No	Treatment outcome at 6 weeks: ROM < TAU Number of sessions: ROM = TAU

Note. BASIS-32 = Behavior and Symptoms Identification Scale – 32 (Eisen, Wilcox, Leff, Schaefer, & Culhane, 1999); BDI-II = Beck Depression Inventory-II (Beck, Steer, & Brown, 1996); BSI = Brief Symptom Inventory (Boulet & Boss, 1991); EDE = Eating Disorders Examination Interview (Cooper & Fairburn, 1987); ORS = Outcome Rating Scale (Miller et al., 2003); OQ-45 = Outcome Questionnaire (Lambert, 2004); SCL-90 = Symptoms Checklist 90 (Derogatis, 1992).

Quality assessment. One strength in the body of ROM research is that most studies are conducted in naturalistic treatment settings, which increase the generalizability of findings. As discussed by Kendrick et al. (2016) however, there are several threats to the validity of findings in ROM studies. The risk of *performance bias* is high as therapists and in most cases also clients, by necessity, are aware of the results of the randomization. Related to this, the risk for *detection bias* is also high; outcomes are typically assessed by client self-report questionnaires and consequently, the outcome assessors are not blinded to conditions. Also the risk for *attrition bias* is high as ROM studies published to date typically have missing outcome data for some of the participants that had been included.

Another potential risk of bias is the assessment of treatment outcomes with the ROM system's measure of progress, which is the case in most ROM studies; as can be seen in Table 1, the majority of the previously published PCOMS studies assessed outcomes with PCOMS' wellbeing measure, the ORS. Using a ROM progress measure to assess the effects of that same intervention is problematic for several reasons. A bias is introduced if clients in the experimental condition complete the measure in every session and consequently, become more familiar with it than clients in the control condition. The external and internal validity of the findings may be questioned; what exactly is the change that is being measured, and how reliably is it measured? The ORS is an ultra-brief, general, four-item wellbeing scale developed for use as a clinical tool rather than as a research instrument, and more comprehensive measures typically have better psychometric properties (Miller et al., 2003).

The present thesis adds to the existing ROM literature by investigating the effects of ROM, as assessed using an independent measure, in a psychiatric setting treating severe clients. Moreover, the thesis explores some potential explanations to the mixed findings in previous research, including whether ROM effects are influenced by client impairment levels, therapist variability, and implementation and training. The question of what the effective elements of ROM might be is also addressed in this work. As such, it represents a step towards better understanding when, for whom, and how ROM influences outcomes, which could help maximize the effects of these interventions.

1.2.3 Influence of client impairment on ROM's effects

In a systematic review of 10 studies, Davidson et al. (2015) observed that effect sizes of ROM tend to diminish with more severe psychiatric populations. This is consistent with PCOMS studies published to date. Three trials (Davidsen et al., 2017; Rise et al., 2016; van

Oenen et al., 2016) were conducted in psychiatric populations and in all of these, treatment outcomes were the same for clients treated with and without PCOMS. The only PCOMS trial to find indications of adverse effects of the intervention (van Oenen et al., 2016), was conducted in an emergency psychiatric center and featured the client sample with the lowest mean initial ORS scores (13.1) of any PCOMS studies published to date. The authors suggested that people in a state of crisis may be less able to reflect on their situation and assume responsibility in treatment, which, according to these authors, is necessary to benefit from ROM. Similarly de Jong et al. (2017) and Errázuriz and Zilcha-Mano (2018) both reported adverse effects of the OQ system for the most severely impaired clients in their studies (non-progressing clients with cluster B personality disorders and several prior hospitalizations or high baseline severity, respectively). These authors speculated that feedback about lack of progress might be demoralizing for severe clients.

Implementing ROM can be costly and time-consuming, and should clearly be avoided if non-effective or even adverse for highly impaired clients. However, not all findings in the literature support this notion. In Hansson et al. (2013), OQ effects were similar for clients with high, medium or low initial distress scores. Moreover, Amble, Gude, Ulvenes, Stubdal, and Wampold (2015) found a near-significant trend towards stronger OQ effect (i.e. the intervention was more effective) with more distressed clients. Thus, it is unclear if ROM effects differ according to clients' impairment levels. The present work addressed this question by investigating initial distress levels as a moderator to PCOMS' effects in a population of moderately to severely impaired individuals.

1.2.4 Therapist variability in ROM's effects

Therapists have been found to differ substantially in their overall outcomes (e.g., Green, Barkham, Kellett, & Saxon, 2014; Okiishi et al., 2006; Okiishi, Lambert, Nielsen, & Ogles, 2003; Saxon, Barkham, Foster, & Parry, 2017), and it is highly feasible that they differ in how ROM influences their outcomes as well. In one RCT, Simon et al. (2012) examined treatment effects with and without ROM for individually for each therapist in their study (n = 6). These authors found that while ROM made a substantial difference for three therapists, the remaining three were equally effective with and without ROM. In a more sophisticated analysis, Anker et al. (2009) used multi-level modeling (MLM) to investigate therapist variability and found significant differences in feedback slopes, indicating that ROM influenced therapists' outcomes differentially. However, using the same data analytic strategy

in larger therapist samples (n = 57 and 110, respectively), de Jong et al. (2012) and de Jong et al. (2014) did not find significant variability between therapists in the effects of ROM on their outcomes.

Some studies have investigated whether therapist characteristics moderate the influence of ROM on outcomes. ROM has been found to be more effective for therapists with a high self-efficacy and therapists with a strong focus on achieving success, but less effective for those with a high commitment to use ROM and those with a strong focus on preventing failures (de Jong & De Goede, 2015; de Jong et al., 2012). If therapists reported making active use of the feedback that ROM provides - which was the case for only 46% of the therapists in de Jong et al. (2012) - ROM was associated with better outcomes for clients not progressing at the expected rate (de Jong et al., 2012). However, Errázuriz and Zilcha-Mano (2018) did not find a differential effect of ROM for the therapists who reported using the feedback (64.7% of all therapists in this sample) and those that did not.

To better understand therapist differences in ROM effects, the present thesis utilized MLM to investigate therapist variability. Moreover, in a qualitative study, we explored when and how therapists make use of negative client feedback to improve the therapy process.

1.2.5 Influence of implementation and training on ROM's effects

The importance of successful clinical implementation of ROM has been emphasized by several authors (e.g., Boswell, Kraus, Miller, & Lambert, 2015; Lucock et al., 2015; Lutz, De Jong, & Rubel, 2015; Mellor-Clark, Cross, Macdonald, & Skjulsvik, 2016; Wampold, 2015; Wolpert, 2014). The effective and sustainable use of ROM may require systematic efforts over extended periods of time, often several years (Boswell et al., 2015; Fixsen, Blase, Naoom, & Wallace, 2009; Mellor-Clark et al., 2016; Miller, Hubble, Chow, & Seidel, 2015). Thus, the mixed results of ROM studies could be related to the differences between studies in the quality of the clinical implementation of these tools.

Implementation is a multifaceted construct and it is not clear how to best assess it. One crucial component of implementation may be training in the use of ROM (de Jong, 2016); such training has been found to increase therapists' motivation, attitudes and skill levels (Willis, Deane, & Coombs, 2009), which could increase the likelihood that they will make active use of the intervention. Thus, studies in which therapists receive extensive training could reasonably be expected to demonstrate larger ROM effects than studies in which little or no training is provided.

Reviewing previous ROM studies however, no such clear relationship between amount of training and ROM effects is apparent. In the case of PCOMS, for instance, one study (Schuman et al., 2015) reported that therapists were not trained at all in the use of PCOMS, and yet, the intervention was found to improve outcomes. At the other end of the continuum, three studies reported that therapists were trained and supervised both prior to and during the study; in the first (Anker et al., 2009), outcomes were superior in the ROM condition, in the second (Janse et al., 2017) only clients with mood disorders benefitted from ROM, and in the final (van Oenen et al., 2016), clients in the ROM condition improved at a slower rate than those in TAU at mid-treatment. Only one previous RCT (Davidsen et al., 2017) has investigated the possibility of ROM's effects changing over time and found this not to be the case.

There are however other indications that training in the use of ROM may be associated with increasing treatment effects over time. For instance, two large-scale, practice-based longitudinal case studies in which therapists worked with ROM while receiving ongoing training in its use (Goldberg, Babins-Wagner, et al., 2016; Miller, Duncan, Brown, Sorrell, & Chalk, 2006) demonstrated that treatment became increasingly more effective over a period of several years. Due to the lack of control group in these studies, it is not clear if the increasing treatment effects were attributable to the ROM training that they received or, for instance, increasing familiarity with the intervention. However, in a similar, practice-based longitudinal study of an agency in which no such continued training in the use of ROM was offered (Goldberg, Rousmaniere, et al., 2016), therapists' outcomes diminished slightly over time. Together, these three case studies suggest that therapists may not necessarily learn to use ROM more effectively with increasing experience alone but that ongoing ROM training and supervision may make a difference.

The data for the present thesis was collected during a four-year implementation process where therapists were regularly trained and supervised in the use of ROM. This made it possible to investigate, in a randomized controlled design, if the effect of ROM was stable or changed in this period. This represents a step towards understanding what it takes to successfully implement ROM, and could also help explain some of the mixed findings in the ROM outcome literature; if ROM's impact on treatment outcomes increases over time, then the timing of measurement within an implementation process and the length of the data collection period could both influence the magnitude of ROM's effect.

1.3 CHANGE MECHANISMS INHERENT IN ROM

1.3.1 Theoretical perspectives

ROM systems are tools to help therapists detect problems in treatment, but they generally do not, like therapy approaches or models, tell therapists what to do to solve these problems. Mechanisms of change in ROM has received little attention in the literature (Wampold, 2015).

The Contextual Feedback Intervention Theory (Sapyta, Riemer, & Bickman, 2005) posits that providing a therapist with negative feedback or information about a discrepancy between their current performance and some desired goal (e.g., helping the client improve) motivates the therapist to engage in corrective action. This is thought to be especially true if the feedback is direct, specific to the therapist's behaviors, promptly delivered after that behavior, and comes from a credible source. ROM systems are designed to fulfill these requirements and provide information that therapists would otherwise have difficulties obtaining (Lambert & Shimokawa, 2011). As such, ROM systems are theorized to work through correcting cognitive biases that prevent therapists from detecting treatment failures (Macdonald & Mellor-Clark, 2014). ROM has been compared to a GPS device that alerts therapists when therapy is off track (Miller et al., 2015). Beyond influencing therapists' behavior, however, this theory does not explain what mechanisms of change inherent in ROM might be.

Miller, Hubble, Duncan, and Wampold (2010) suggested that the PCOMS mobilizes the common factors of psychotherapy (Lambert, 1992; Wampold & Imel, 2015), particularly the working alliance, which is robustly associated with psychotherapy outcomes (Horvath & Bedi, 2002; Horvath, Del Re, Flückiger, & Symonds, 2011; Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). The PCOMS explicitly targets the working alliance through the SRS, which can be viewed as a tool to detect alliance ruptures or strains in the collaborative working relationship (Safran & Muran, 2006). Also the OQ system has alliance-fostering tools which are utilized when clients are in risk of negative outcomes; the Assessment of Signal Cases (ASC) and Clinical Support Tools (CST), which include alliance assessments and suggestions about what therapists can do to improve the alliance.

Thus, ROM is thought to work through prompting corrective action by therapists when they are alerted that their clients are in risk of treatment failure. It is possible that these actions help improve the quality of the common factors of psychotherapy, particularly the working

alliance. In the following, research into therapists' responses to negative feedback, and ROMs effect on the working alliance, will be reviewed.

1.3.2 The influence of feedback on therapists' behavior

Researchers are beginning to explore how therapists respond to negative feedback. The notion that negative or corrective feedback impacts the subsequent therapy process was supported by Probst et al. (2013). In this study, trajectories or change for clients progressing at the expected rate and those not doing so were similar until the point where a warning signal was given; from that point on however, clients treated with ROM improved while those in TAU did not. Douglas et al. (2015) demonstrated that warning signals increased the likelihood that therapists addressed topics related to progress and process with their clients. A qualitative study found that therapists were influenced by their existing practices in how they responded to negative feedback (Oanes, Karlsson, & Borg, 2017). This point was illustrated in a case study (Snyder & Aafjes-van Doorn, 2016), where a therapist was aided by a ROM measure in detecting an error of judgment that he had made with a client, and subsequently understood and handled that clinical error according to the principles of the Control Mastery Theory, which was his preferred therapy model.

Other qualitative studies have indicated that therapists value ROM's ability to stimulate to collaboration in therapy, allow them to adopt a meta-perspective on therapeutic process and practice, and increase their awareness of the clients' perspectives, as summarized in a review of seven studies (Oanes, Anderssen, Karlsson, & Borg, 2015). For instance, Sundet (2012, 2014) found that both therapists and clients experienced the PCOMS measures as useful conversation tools that both opened new possibilities and topics in therapy, and helped structure those conversations.

As discussed above, therapists do not always make active use of ROM feedback to guide treatment (de Jong et al., 2012; Errázuriz & Zilcha-Mano, 2018). Potential reasons for this are negative attitudes towards ROM, challenging emotions elicited by negative feedback, external attributions of lack of progress in therapy ('blaming the client'), or the fear of being a 'bad therapist' (de Jong, 2016). Therapists' responses to ROM feedback may not be that different from how people in general respond to feedback. The risk of losing face and damaging one's self-image is known to prevent people from seeking negative feedback (Anseel, Beatty, Shen, Lievens, & Sackett, 2015), and in several qualitative studies, therapists have disclosed feelings of guilt, anxiety, incompetence, confusion, and irritation when

confronted with their clients' dissatisfaction (Coutinho, Ribeiro, Hill, & Safran, 2011; Hill et al., 2003; Hill, Nutt-Williams, Heaton, Thompson, & Rhodes, 1996; Holmqvist, Hansjons‐Gustafsson, & Gustafsson, 2002; Moltu, Binder, & Nielsen, 2010; Snyder & Aafjes-van Doorn, 2016).

Better understanding how therapists experience receiving negative feedback from their clients in general (i.e., not limited to ROM feedback), and under what circumstances they are able to respond constructively to it, could prove valuable in terms of understanding, for instance, how therapists work with client feedback to improve therapy processes and why some therapists are hesitant to employ ROM or choose not to make active use of ROM feedback. These questions were addressed in the present thesis.

1.3.3 The working alliance in ROM

Relatively few studies have researched the alliance in relation to ROM and, in those which have, the evidence is mixed. In one trial, alliance ratings at six months' treatment were the same with and without ROM (Rise et al., 2012). Two more recent studies (Janse et al., 2017; McClintock, Perlman, McCarrick, Anderson, & Himawan, 2017) found more alliance improvement over time with ROM. This suggests that ROM may be associated with alliance growth from the beginning of treatment and onwards, but not necessarily superior alliances at any given point in time. However, contrary to findings alliance improvements predict better treatment outcomes (e.g., Falkenström, Ekeblad, & Holmqvist, 2016; Falkenström, Granström, & Holmqvist, 2013; Kivlighan Jr & Shaughnessy, 2000; Owen, Miller, Seidel, & Chow, 2016; Safran, Muran, & Eubanks-Carter, 2011; Zilcha-Mano & Errázuriz, 2015), in the two latter studies ROM did not improve overall outcomes, as would be expected if the alliance mediated the effects of ROM.

The added benefit of specific alliance feedback, such as the SRS or the CSTs, is also uncertain. In their meta-analysis of six OQ trials, Lambert and Shimokawa (2011) reported that effect sizes were higher in the studies in which therapists used the CSTs, but to our knowledge no studies have compared the effect of OQ alone to OQ in conjunction with CSTs. Two dismantling studies of the PCOMS have been published. In the first, Reese et al. (2013) found no differential effect on alliance when SRS scores were fed back to therapists or not. In the second, Mikeal, Gillaspy Jr., Scoles, and Murphy (2016) found treatment outcomes not to differ when clients were given just the SRS, versus only the ORS or, as recommended by the developers, both tools simultaneously. Similarly, Errázuriz and Zilcha-Mano (2018) did not

find that providing therapists their clients' with session-by-session scores on the Working Alliance Inventory (WAI; Hatcher & Gillaspy, 2006) augmented the effect of the OQ system. In an earlier report from this trial however, the alliance-outcome association was found to be stronger when therapists were given access to their clients' WAI scores (Zilcha-Mano & Errázuriz, 2015), which does suggest that the alliance may play a role in the effect of ROM.

In sum, empirical evidence in support the alliance as a mechanism through which ROM works, is scarce. In this thesis, as the first ROM study to date, we tested the alliance as a mediator to ROM's effects.

1.4 THE ROLE OF CLIENT FEEDBACK IN THERAPISTS' PROFESSIONAL DEVELOPMENT

A large-scale qualitative study found that therapists have a sense of continually evolving as a result of their work with clients and in particular, information that they gain from their clients' reactions to their actions (Ronnestad & Skovholt, 2003, 2012). As discussed above, two case studies (Goldberg, Babins-Wagner, et al., 2016; Goldberg, Rousmaniere, et al., 2016) have demonstrated increasing effectiveness over time for therapists working with ROM. These tools provide continuous feedback on therapists' performance and as such, have a considerable potential as a learning tool (Miller et al., 2015). ROM may also increase therapists' motivation to reflect on their own practices and move beyond their personal and professional comfort zone, as found by Oanes et al. (2015) in their review of qualitative studies.

However, using ROM with clients and reflecting on their own practice may not in itself be sufficient for therapists to improve their outcomes over time. Miller et al. (2015) suggested that the process of translating insight gained from feedback into actual behavior changes may require considerable effort. They recommended that therapists engage in 'deliberate practice', i.e. "setting aside time for reflecting on one's performance, receiving guidance on how to improve specific aspects of therapeutic practice, considering any feedback received, identifying errors, and developing, rehearsing, executing, and evaluating a plan for improvement" (Miller et al., 2015, p. 453; see also Ericsson, Hoffman, Kozbelt, & Williams, 2018; Tracey, Wampold, Lichtenberg, & Goodyear, 2014). The impact of deliberate practice on therapists' overall effectiveness has received some preliminary support (Chow et al. 2015). To date however, relatively little is known about the role of client feedback in therapists' professional development.

On the basis of therapists' accounts of situations in which they had received negative feedback from clients, the present thesis explored the process by which therapists learn something from negative feedback that leads them to change their behavior with new clients.

1.5 SUMMARY OF PREVIOUS RESEARCH

- There is a considerable variability in findings of previous ROM studies, suggesting that more knowledge is needed on for whom, under what circumstances, and how ROM improves outcomes.
- The risk of bias in the body of literature is relatively high due to lack of blinding, attrition, and the use of ROM measures to assess the outcomes of those same measures.
- There are some indications that ROM's effects could differ across client impairment levels and between therapists, but existing evidence is not unequivocal.
- The question of how ROM works has received little attention. Feedback theory suggests that ROM influences the therapists' behavior, for instance, in ways that improve the working alliance.
- Few studies have investigated the role of the alliance in ROM. Some evidence suggests that ROM may be associated with alliance improvements over time.
- Client feedback may help therapists in their professional development.
- Little is known about how therapists in general experience receiving feedback from clients and under what circumstances they change their behavior as a result of feedback from their clients.

1.6 AIMS OF THE THESIS

Based on the mixed findings in prior ROM research, this thesis aimed to investigate the overall impact of ROM on psychotherapy outcomes in outpatient adult hospital mental health care, as well as explore variables that might influence and explain this effect. An overall aim was to provide new knowledge relevant for understanding when ROM might be expected to improve outcomes and when it might not.

The thesis is based on data from two studies. Study 1 (presented in Papers I and II) was a randomized controlled trial investigating the overall effect of the PCOMS ROM system on treatment outcomes, and potential moderators to this effect. Study 2 (presented in Paper III) was a qualitative exploration of therapists' experiences of receiving negative feedback from their clients.

The following research questions were investigated:

a. Does ROM improve treatment outcomes in a hospital-based mental health clinic? (Paper I)
b. Does the effect of ROM differ according to how distressed clients are, and does it differ between therapists? (Paper I)
c. Is the effect of ROM stable or does it change over the course of an implementation process (Paper I)?
d. Is some of the effect of ROM on outcomes explained by a positive effect of ROM on the alliance? (Paper II)
e. How and when do therapists work with negative client feedback in ways that contribute constructively to the therapy process and/or their own professional development (Paper III)?

2. MATERIALS AND METHODS

2.1 STUDY 1: RANDOMIZED CLINICAL TRIAL (PAPERS I AND II)

2.1.1. Design

In a naturalistic randomized clinical superiority trial, waitlist psychotherapy clients were randomly assigned to one of two conditions: 'Routine Outcomes Monitoring (ROM)' or 'Treatment as Usual (TAU)'. Randomization was performed by the first or second author using a web-based randomization program for medical research (www.webcrf.medisin.ntnu.no) and a 1:1 allocation ratio. There was no blinding of clients, therapists or researchers to the results of the randomization. Clients in both conditions were given non-manualized outpatient individual therapy according to the standard at the hospital mental health center in which the trial took place. Therapists worked with clients in both the experimental (ROM) and control (TAU) conditions; the only difference between conditions was that the PCOMS measures were administered in the former, and not in the latter.

2.1.2 Procedures

Intervention. The PCOMS consists of two client self-report questionnaires, the Outcome Rating Scale (ORS; Miller et al., 2003) and the Session Rating Scale (SRS; Duncan et al., 2003). The ORS measures the client's current level of wellbeing in four items (i.e., symptoms, relational functioning, social role functioning, and global functioning). The SRS measures the client's experience of the alliance in the current session, in four items (i.e., therapeutic relationship, goals and topics, approach or method, and overall experience of the alliance). Both measures are scored on visual analogue scales; clients place marks on 10-cm lines that range from poor to good, resulting in numerical values that range from 0 (minimum wellbeing/experienced the alliance as very poor at today's session) to 10 (maximum wellbeing/experienced the alliance as very good at today's session) and total scores ranging from 0 to 40.

Both the ORS and the SRS questionnaires were administered on computer tablets using a web-based scoring program (www.fit-outcomes.com). Clients' scores on both measures were displayed as graphs and compared to their scores from previous sessions as well as their expected trajectories of change. When the ORS scores fell below the expected treatment trajectory or when SRS scores fell below the clinical cutoff or dropped by 1 point,

warnings were given in the form of yellow or red signs on the screen. Therapists were trained to share and discuss information gained through the ORS and the SRS with the client. If problems in a client's response to therapy were indicated, therapists were instructed to engage the client in a dialogue about how therapy could be improved, and to adjust the treatment accordingly.

Clinical training, implementation and supervision. The process of implementing ROM began about six months prior to the onset of the trial, with one of the developers of the PCOMS, Scott D. Miller, giving a one-day training workshop at the clinic. Each therapist was given a copy of the PCOMS manuals (Bertolini & Miller, 2012). One-day training and group supervision workshops were organized twice each year, and training and supervision sessions were conducted once each month throughout study period. During the training events, the therapists were taught how to introduce, administer, interpret, and integrate PCOMS into therapy. In supervision, client cases were discussed. Participation was obligatory for all therapists, but no attendance records were kept. The principal investigators were responsible for much of the training and supervision, and other experienced supervisors and trainers contributed at intervals throughout the implementation process.

Fidelity. To assess whether the PCOMS measures were administered or withheld according to protocol for the two conditions, therapists rated, at each client's treatment termination, how frequently the ORS and the SRS had been administered in that therapy (rated as: 1 = *every session;* 2 =*some sessions*; 3 = *never*). Data was available for 118 cases. In the TAU condition, the PCOMS measures were reported as *never* administered to 59 clients and *every session* to one client. In the ROM condition, the measured were reportedly administered *every session* to 51 clients, *some sessions* to three clients, and *never* to five clients. These data indicate that the therapists administered the PCOMS measures as intended for all cases but six.

2.1.3 Participants

Clients. Inclusion criteria were being referred for and assessed by the clinic's intake team as eligible for individual outpatient treatment at the clinic. Individuals were excluded from participation if unable to complete questionnaires due to illiteracy, very low cognitive functioning, or poor understanding of the Norwegian language.

The final sample consisted of 161 clients. Participant characteristics are presented in Table 1 of Paper I. Their mean age was 34.1 years old (*SD* = 11.6). Most clients were female

(*n* = 100, 63.3%, data missing for three clients). About half of the clients were single (*n* = 74, 46.5%; 2 missing). Twenty-four clients (15.1%; 2 missing) lived alone and 28 (17.8%; 4 missing) reported not having anybody in whom they could confide. Twenty-seven clients (17.1%; 3 missing) had no education beyond primary school, and 77 (50.0%; 7 missing) were not working, either being on sickness benefits, unemployed, or retired. The most frequent main diagnostic categories according to the International Statistical Classification of Diseases and Health Related Problems (ICD-10; World Health Organization, 1992), were the following: Affective disorders (*n* = 59; 30.0%), anxiety disorders (*n* = 50; 30.1%), hyperkinetic disorders (ADHD) (*n* = 20; 10.0%) and personality disorders (*n* = 17; 8.7%). Nineteen participants (9.7%) were diagnosed with other diagnoses including psychosis, eating disordes, and autism spectrum disorders. Thirty-five clients (17.9%) had one or several comorbid diagnoses, and 22 clients (11.2%) were undiagnosed.

Therapists. All of the therapists on the treatment team were required to treat the participants in this study. A total of 20 therapists (16 women and four men) participated in the study and treated 1–19 clients each (*mean* = 7.6, *SD* = 5.6). Eleven therapists were clinical psychologists, six were psychiatrists, and three were other mental health care professionals. On a 7-point Likert scale (1 = *very little* to 7 = *very much*), the therapists reported being most influenced by psychodynamic therapy models (*median* = 6, *range* = 2–7), followed by humanistic/existential (*median* = 5, *range* = 1–6) and cognitive (*median* = 4, *range* = 2–7) models. Due to staff turnover in the study period, their experience working with PCOMS ranged from 1 month to 5 years at the end of the inclusion period. Seven therapists worked at the clinic throughout the trial period. These treated 93 clients (57.8% of the total sample) of which 66 (62.3%) were included in the analyses for Paper I.

Inclusion and participant flow. Inclusion to this trial was performed on a weekly basis. The clinic's intake team assessed individuals referred for treatment for suitability for treatment and eligibility to participate in this trial. The assessments were based on referral letters, which typically contained a brief description of the presenting problem and relevant medical or psychiatric history. Individuals deemed eligible for participation were invited to participate via mail and telephone. Prior to their first treatment session, prospective participants met in person with one of the principal investigators to give informed consent, complete baseline measures, and undergo randomization. Shortly thereafter, participants entered treatment. The first participant started treatment in November 2012 and the last one in

January 2016. Data collection for this study was completed in February 2017, resulting in a trial period of about four years.

A participant flowchart is presented in Figure 1 of Paper II. The clinic received 1 655 referrals in the trial period. In addition to those who were not considered eligible for treatment at the clinic and thus, partipation in the trial, an unknown number of individuals were not invited to participate due to clerical errors (for example, in periods of the trial the intake team forgot to assess all referrals for eligibility). A total of 659 clients (40% of all referrals) received invitations to participate. Recruiting ended when 170 individuals (25.8% of those invited to participate) had agreed to participate and been randomized. Nine participants (5.3%) received no therapy sessions and were discharged without treatment, leaving 161 participants in the final sample. Of these, one participant (0.6% of the final sample) had missing data at baseline, 16 (9.9%) at session one, 47 (29.2%) at two months' treatment, and 47 (29.2%) at post-treatment. There is some overlap in the missing data as some clients had missing data on more than one measurement time. In total, 70 clients (43.5%) failed to return one or more measure. In addition, 10 clients changed therapist mid-treatment due to staff turnover and consequently, had missing therapist-level data. Multi-level models (MLMs; see Statistical analysis subsection) utilize all available data rather than casewise deletion of cases with missing data and consequently, cases are included if they have sufficient data to estimate at least one parameter in a given model. In Paper I, 106 cases (65.8% of the final sample) were included and in Paper II, 143 cases (88.8%).

2.1.4 Measures

Impairment. The primary outcome in Papers I and II was posttreatment level of symptoms and psychosocial functioning, measured at baseline (T0) and posttreatment (T3) with the Behavior And Symptoms Identification Scale (BASIS-32; Eisen, Wilcox, Leff, Schaefer, & Culhane, 1999). BASIS-32 is a 32-item self-report measure of a broad range of symptoms and problems. Items are rated on a 5-point Likert scale (0 = *no difficulty;* 4 = *extreme difficulty*), generating five subscale scores (relation to self/others, daily living/role functioning, depression/anxiety, impulsive/addictive behavior, and psychosis) and an overall mean score, which was utilized for this study. The internal consistency was high, with a Cronbach's alpha of .94 for the pretreatment scores, similar to an earlier report (Eisen et al., 1999). The BASIS-32 was found previously to be sensitive to change and moderately correlated with other measures of symptoms and function (Eisen et al., 1999). Several

validation studies (Doerfler, Addis, & Moran, 2002; Hoffmann, Capelli, & Mastrianni, 1997; Jerrell, 2005; Klinkenberg, Cho, & Vieweg, 1998; Russo et al., 1997) have replicated the sound psychometric properties of the BASIS-32.

The timing of treatment within the implementation period. To investigate whether the effects of ROM on outcomes changed or remained stable over the duration of the trial, we registered for each case the number of months from the beginning of the trial to when the case was initiated, resulting in scores that ranged from 0 (started treatment in November 2012) to 38 (started treatment in January 2016). Figure 2 in Paper I shows the number of clients who initiated treatment each month of the trial.

Working alliance. The quality of the working alliance was assessed at session one (T1) and two months' treatment (T2) with the short version of the Working Alliance Inventory (WAI-S; Horvath & Greenberg, 1989; Tracey & Kokotovic, 1989), a 12-item questionnaire based on Bordin (1979) three working alliance dimensions: Emotional bond and agreement on the goals and tasks of therapy. Items are scored on a 7-point Likert scale from 1 (*strongly disagree*) to 7 (*strongly agree*), with higher scores indicating better working alliance. WAI-S is widely used in research. Despite a well established reliability in previous studies (Busseri & Tyler, 2003; Hanson, Curry, & Bandalos, 2002; Horvath, 1994; Tracey & Kokotovic, 1989), the item-total correlation for two items with reversed wording was low in the present study (.259 and .082, respectively). These items were removed following the recommendations of Field (2013), resulting in improved internal consistency (i.e. Cronbach's alpha increased from .899 to .936 at T1 and from .949 to .955 at T2).

2.1.5 Ethics

The study protocol was approved by the Regional Committee for Research Ethics (Case number 2011/1711), and the trial was registered on Clinical Trials (clinicaltrials.gov; identifier: NCT01796223). The study was conducted in accordance with the principles in the Declaration of Helsinki. Participation was voluntary and non-participating clients were offered standard outpatient treatment at the mental health clinic. Participants were free to withdraw from the study at any point in time without any negative consequences. All included participants had signed a written informed consent form prior to inclusion. Participating clients' identity was concealed to protect their privacy and confidentiality. Based on prior research, there was a reasonable likelihood that the population would benefit from the

intervention. Clients allocated to the control condition received the active, standard treatment at the mental health center.

2.1.6 Statistical Analysis

Handling of missing data. As described above, missing data was a challenge in this trial. We mitigated the effect of this in three ways. First, as described above, the use of MLMs implies that all available data was included in the models (in contrast to casewise deletion of cases with missing data points). Second, to determine if there were systematic differences that might bias our results between cases with missing data points and cases with complete data sets, we compared these two groups on all baseline variables (using t-tests for continuous and chi square tests for categorical variables). If variables that differed between the two groups were found to predict the outcome variables and controlling for them in the planned models changed the results of these models (i.e. altered the estimates for the other predictors, explained more variance, or improved the model fit), they were retained as covariates in the final models. Third, missing values were imputed using the maximum likelihood imputation procedure (Schafer & Graham, 2002) with all other observed variables as auxiliary variables. All analyses were performed twice, first with complete cases only (i.e. no imputation) and then with the imputed data set. The results from the complete cases only data sets are presented here due to the uncertainty that is introduced by imputing with a large amount of missing data.

General analytic strategy. To properly model the nested structure with each therapist treating several clients (Wampold & Serlin, 2000), a series of multilevel models (MLMs; Snijders & Bosker, 2012) were fitted using the Mplus statistical software (Muthén & Muthén, 1998-2017), with clients at level 1 nested within therapists at level 2. All variables were measured at the client level and we did not include any therapist level predictors.

In Paper I, all parameters were estimated using maximum likelihood estimation (MLE). In Paper II, we expected a non-parametric distribution for the indirect effects. Consequently, parameters were estimated with Bayesian estimation, which makes no assumptions about the prior distribution but instead, utilizes a posterior distribution based on the observed values (Hamaker & Klugkist, 2011; Robert, 2007). The Bayesian analyses were performed with 30.000 iterations, and no starting value information. Bayesian posterior trace plots for each parameter were inspected to determine if the models converged. We reported

median point estimates and posterior standard deviations (*SD*s) for the parameters as well as Credibility Intervals (Crls), which are based on the percentile points of the posterior probability distribution and describe the range in which the true values of the parameters are likely to be. In both papers, variance explained was assessed by R^2, and proportion of variance explained by therapists by the intra-class correlation coefficient (ICC). In Paper I, model fit was assessed by Akaike (AIC) and Bayesian (BIC) estimations and the loglikelihood (llg) chi square test, and in Paper II, by the Deviance Information Criteria (DIC).

The a priori hypotheses in this trial were directional: Superior outcomes in the ROM condition, positive effects of initial impairment on posttreatment distress levels, negative effects of clients' time of treatment, a positive effect of ROM on the alliance, a negative effect of alliance on treatment outcome, and a negative indirect effect of ROM through the alliance on treatment outcomes. Accordingly, we report one-sided significance tests with an alpha level of .05. We also report 90% CIs and CrIs, of which the upper or lower bound (depending on whether the effect is hypothesized to be positive or negative) represent the value below or above which we would expect 95 % of future observations to fall. As only one side of the CIs (and CrIs) are of interest when hypotheses are directional, the resulting error rate is 5% (Pocock, 2003).

Tests of hypotheses, Paper I. The clinical significance of the difference in outcomes between the ROM and TAU conditions was assessed according to the Reliable Change Index - Improved Difference, RCI_{ID} (Hageman & Arrindell, 1993). Using this parameter, cases were categorized by whether they demonstrated reliable improvement, no change, or reliable deterioration from pre- to post-treatment. Multilevel models 1 through 4 examined the effects of client level variables in random intercept, fixed slope models, allowing for therapist variability in the intercepts for each predictor but modeling slope coefficients as being equal across therapists. We first controlled for clients' grand mean centered pretreatment BASIS-32 score (model 1) and examined the overall effects of ROM (model 2). We then tested for moderation of the ROM effect by the point in time within the implementation period at which clients were treated (model 3) and clients' initial impairment (model 4). Finally, in models 5a, b, and c we investigated therapist variability in ROM effects by retaining all predictors from model 4 and fitting random slopes between levels for Condition (model 5a), the Time*Condition interaction (model 5b), and the Pre*Condition interaction (model 5c).

Tests of hypotheses, Paper II. Allowing the intercepts for the dependent variable and the mediator to vary at random between therapists, we fitted a two-level mediation model with alliance change as mediator to the effect of ROM on treatment outcome at the client level. This was done by testing the effect of ROM on alliance change (by convention referred to as path *a*), the effect of alliance change on treatment outcome (i.e. post-treatment distress controlled for initial distress; path *b*), the indirect effect of ROM on outcome via the alliance (i.e. the product of paths *a* and *b*), and the residual direct effect of ROM on treatment outcome when the indirect effect was controlled for (path *c'*). Paths *a, b, c*, and *ab* were modeled simultaneously. Mediation was supported if the estimates for paths *a* and *b* as well as the indirect effect *ab* were statistically different from 0. The total effect *c* of ROM on outcomes was inferred from the sum of the indirect and direct effects, as recommended by Kenny, Korchmaros, and Bolger (2003) for multilevel mediation models. As an indication of effect size, we reported the extent of mediation, with is given by *ab*/*c*.

2.2 STUDY 2: QUALITATIVE STUDY (PAPER III)

2.2.2 Design

Because of the explorative nature of the research questions, we adopted the qualitative methodology of Consensual Qualitative Research (CQR; Hill, 2012; Hill et al., 2005). Its main benefits are the integration of multiple perspectives to yield a more complex and less biased understanding of the data through rigorous and replicable analytic steps.

2.2.3 Procedures

Recruitment and adminstration. The data for this research was collected in a questionnaire (see the Measures section below). Sixty therapists working at the hospital mental health center were invited to participate. Information about the study was provided both by the first author in person, and via an e-mail which also contained a link to the questionnaire. In total, 20 therapists (33 %) returned the questionnaire. Two respondents did not describe a specific example and were excluded from the analysis, yielding a total of 18 cases in the final sample. The questionnaire was administered via a web based survey program (www.questback.com).

Working as a CQR Team. Following CQR guidelines, in each step in the analysis, judges individually analyzed a previously agreed upon subset of cases or domains before working with the team to compare, discuss, adjust and reach consensus. The process was then shortcut by splitting the team into pairs of judges, with the principal investigator serving on each pair, and sharing the remaining cases/domains between them. We counteracted power differences in the team by encouraging open expressions of differences of opinions and discussing differences in an accepting manner until the team reached consensus.

2.2.4 Participants

Informants. The participants were 18 therapists at a Norwegian mental health hospital. Demographic data was available for 16 of the therapists. The group consisted of 10 women and 6 men between the ages of 28 and 64 years old (M = 47.4). Seven were clinical psychologists, 6 psychiatrists, and 3 other health care professionals. Highly experienced therapists dominated the sample. Five participants (31.3 %) had worked as a therapist for more than 20 years, 10 (62.5 %) for 10-20 years, and 1 (6.3 %) for less than five years.

All 18 therapists provided information about theoretical orientation and attitudes towards clients´ feedback. On a 4-point Likert scale (1 = low, 4 = high), they rated themselves as being strongly influenced by psychodynamic models (M = 3.56, SD = 0.70), followed by cognitive/behavioral models (M = 2.67, SD =0.78) and humanistic/existential models (M =2.61, SD =0.49). Also on a 4-point Likert scale (1 = low, 4 = high), participants indicated that they felt confident as therapists (M =3.1, SD =0.47) and were highly (M =3.3, SD =0.49) concerned with their clients' perceptions of them and their way of working. Nine therapists (50 %) reported receiving process feedback (i.e. meta-communications from clients about treatment) daily, 5 (27.8 %) weekly, and the remaining 4 less frequently. Ten therapists had worked with the PCOMS for a period ranging from 2 months to 15 years, and eight had no experience with any ROM systems.

Researchers. Following CQR guidelines (Hill et al., 2012), four researchers or judges conducted the investigation, and two auditors overlooked the process and gave feedback about the judges' conclusions throughout the process. Team members were selected to ensure a diversity of opinions and viewpoints. The principal investigator was a female, eclectically oriented clinical psychologist who at the time of the investigation worked on a doctoral thesis on ROM. The second judge was a female employee at a service user competence center, with experience being a therapy client and professional interest in examining psychotherapy

processes from the client's point of view. The third judge was the male head of research department at the hospital mental health center where the investigation took place, and the fourth was a male, psychodynamically oriented clinical group psychologist. All judges had some prior experience conducting qualitative research. The auditors were a male professor in psychology and a female professor in psychiatry, both skilled in qualitative research methodology.

To increase awareness of factors that might influence the understanding of the data so that these might be set these aside or 'bracketed' throughout the process, the team of judges reflected upon, discussed and recorded their expectations (i.e. anticipated findings) and biases (i.e. personal issues that might make it difficult to respond objectively to the data) early in the investigation.

2.2.5 Measures

The *Negative Client Feedback Questionnaire* (NCFQ) was developed for this investigation in the following manner: First, the principal investigator conducted two face-to-face interviews with therapists to gain a preliminary understanding of the topic. Then, a pilot questionnaire was developed based on the interviews as well as our reading of relevant research literature and our own experiences as therapists and/or therapy clients. Finally, to test the questionnaire, it was administered to three therapists, and their answers as well as feedback from the external and internal auditors helped further refined the questions. Data from the pilot studies was not included in the analysis.

In the final questionnaire, therapists were asked to identify one specific episode when they had received negative feedback from a client. The experience was then explored in detail through several open-ended questions followed a structure similar to that used in several other CQR investigations (Rhodes et al., 1994, Coutinho et al. 2011): a) background of the event, b) description of the event and immediate context, c) the participant's thoughts, feelings and actions during the event, d) how the event evolved, e) how the participant understands the event, and f) consequences of the event. An English translation of the full questionnaire is included in the Appendix.

2.2.6 Ethics

The project was registered with the Norwegian Data Protection Authorities. The anonymity of participants was secured as follows: E-mails with personal links to the survey were sent to each of the 60 invited therapists. These personal links were deleted following completion of the survey, and all demographic information was separated from the qualitative data by the administrator, so that no identifying information was contained in the raw data material that was made accessible to the research team. Consent to participation was given by completing the survey.

2.2.7 Qualitative analysis

The three major steps in a CQR data analysis are as follows: a) segment raw data into domains, b) formulate core ideas case for case, and c) cross-analyze across all cases to identify similarities and formulate categories. See Hill (2012).

Coding of domains and core ideas, and audit. Starting with a preliminary domains list based on the topics covered in the questionnaire, we sorted or coded the raw data (text from the questionnaire) into main thematic areas while continually modifying the domains list to fit the data. Core ideas (i.e., formulations of the content of interview data in clear and concise wording and incorporating relevant context; Hill et al. 2012) were then developed by carefully reading each case, parsing the interview data into smaller units according to content, and agreeing upon wording of the core idea. The resulting core ideas, with corresponding raw data and organized by domains case by case, were given to the auditors. Their feedback was discussed in the team, resulting in adjustments when deemed appropriate.

Cross-analysis, audit, and frequency calculations. Working domain for domain and across all cases, core ideas that were similar in content were grouped together. Each of these groups or categories was given a label that reflected the content. Categories as well domains were repeatedly modified by frequently going back to the raw text to make sure that the categories represented the data, until a stable list of categories emerged. The list of domains and categories were audited and adjustments were made accordingly, resulting in a final three-level structure of the data: Domains consisting of main categories consisting of sub-categories. Frequency labels were assigned to each of the categories according to how many cases it applied to. Following Hill's (2012) recommendation, categories were labeled *general*

if present in all or all but one of the cases*, typical* if present in the range from half of the cases and up to the cutoff for the general, and *variant* if present less than half of the cases.

Development and comparison of subgroups. Following cross-analysis, we examined the category list with the research question ("When do therapists learn from negative feedback?") in mind. Two categories (titled "Repair" and "Meets new clients differently") were considered to be particularly relevant as they demonstrated therapist behavior change as a result of the feedback and thus, represented different manifestations or applications of learning. Accordingly, we sorted cases into two groups based on these categories, leaving remaining cases in a third group.

For each of the three groups of cases, categories were assigned frequency labels according to the same rules as those that guided the frequency calculations for the entire sample (i.e. the category was considered *general* if present in all or all but one of the cases within that group, *typical* if present in the range from half of the cases up to the cutoff for general within that group, and *variant* if present in less than half of the cases within that group; in addition, a category was given the frequency label *none* if not present in any cases within a given group). When comparing groups of cases, we followed the recommendations made by Hill et al. (2012). Categories were considered more or less frequent in a given group if differing by two frequency categories from one or both of the other two groups (i.e. general vs. variant, typical vs. none). A comparison of cases described by ROM versus non-ROM users was done following the same procedure.

3 SUMMARY OF RESULTS

3.1 PAPER I (STUDY 1)

The effects of Routine Outcome Monitoring (ROM) on therapy outcomes in the course of an implementation process. A randomized clinical trial.

Brattland, H., Koksvik, J. M., Burkeland, O., Gråwe, R. W., Klöckner, C., Linaker, O. M., Ryum, T., Wampold, B., Lara-Cabrera, M. L. & Iversen, V. *Journal of Counseling Psychology,* 2018 (In press)

In a randomized controlled trial, we demonstrated superior treatment outcomes for clients receiving treatment with the PCOMS ROM system compared to those receiving treatment as usual (ROM). Clients in the ROM condition were 2.5 times more likely than those in TAU to demonstrate reliable improvement from pre- to post-treatment. A small, but significant ($d = 0.26$, $p = .037$), overall effect size was obtained when controlling for therapist variability in a two-level model. The superiority for ROM over TAU increased significantly over the duration of the four-year trial. ROM effects did not differ across clients' initial distress levels. Differences between therapists accounted for 9%–10% of the variability in outcomes, and there were no significant differences in ROM effects between therapists.

Does ROM improve treatment outcomes in a psychiatric population (Research question a)? The results support the use of ROM in psychiatric treatment. Clients receiving treatment with ROM at a hospital-based mental health center benefitted more from treatment than those receiving treatment without ROM.

Does the effect of ROM differ according to how distressed clients are, and does it differ between therapists (Research question b)? Clients' initial distress level were not found to moderate ROM's effects on outcomes. Therapists were not found differ in the impact of ROM on their outcomes. The interpretation of this finding is however uncertain due to the low number of therapists included in this study.

Is the effect of ROM stable or does it change over the course of an implementation process (Research question c)? The effect of ROM increased over this four-year study and consequently, clients treated later in the implementation period benefitted more from ROM than those treated earlier. This suggests that ROM's impact on treatment outcomes may depend on when during an implementation process outcomes are measured.

3.2 PAPER II (STUDY 1)

Does the alliance mediate the effects of Routine Outcome Monitoring? A randomized clinical trial.

Brattland, H., Koksvik, J. M., Burkeland, O., Klöckner, C., Lara-Cabrera, M. L., Miller, S. D., Wampold, B., Ryum, T., & Iversen, V. C. (Submitted, April 18, 2018)

Building on Paper I, we investigated if the positive effect of ROM on treatment outcomes was mediated by the working alliance. ROM had a significant positive effect on the working alliance at two months' treatment controlled for first session alliance ($p = .011$), indicating an alliance improvement for clients in the ROM condition. Higher alliance ratings predicted better treatment outcomes ($p = .032$). There was a significant indirect effect of ROM through the alliance ($p = .043$), and this explained an estimated 23.0% of the effect of ROM on outcomes. In a post. hoc analysis, we found that therapists varied significantly in the impact of ROM on the alliance as well as the impact of the alliance on treatment outcomes.

Is some of the effect of ROM on outcomes explained by a positive effect of ROM on the alliance (Research question d)? Consistent with a theory of the working alliance as one of the change mechanisms inherent in ROM, the alliance improved more in the ROM than TAU condition from session one to two months' treatment, and the alliance improvement explained some of the superior treatment outcomes in the ROM condition.

3.3 PAPER III (STUDY 2)

Learning from clients: A qualitative investigation of psychotherapists' reactions to negative verbal feedback.

Brattland, H., Høiseth, J. R., Burkeland, O., Inderhaug, T. S., Binder, P. E. & Iversen, V. C. *Psychotherapy research,* 2016.

Therapists' experiences of, reactions to, and learning from negative client feedback was explored in a qualitative investigation. Receiving feedback was experienced as challenging, but educational, and therapists generally understood the feedback differently in retrospect then they did as the situation occurred.

Improved therapy processes ("Immediately applied learning") were described in cases in which therapists received face-to-face communicated negative feedback that was specific to something therapists had done or failed to do, and responded by flexibly accommodating the client while at the same time maintaining their own therapeutic strategy. These cases were

characterized by therapists attributing the client's dissatisfaction to the client rather than to themselves, and experiencing irritation towards the client as well as negative self-directed emotions, which they made conscious efforts to regulate.

Changes in therapists' behaviors with subsequent clients ("Retrospectively applied learning") was described in cases in which therapists had received specific and face-to-face communicated negative feedback, but had not been successful in improving the subsequent therapy process. These cases were characterized by therapists experiencing shame and guilt, attributing the client's dissatisfaction towards themselves, giving in to the client's request (e.g., by trying to change their therapeutic style), and reflecting on the experience in retrospect.

The feedback generated new ideas that had not been translate into behavior changes ("Non-applied learning") in cases in which the feedback was non-specific and indirectly communicated, and clients immediately discontinued therapy. These situations did not elicit strong feelings in therapists.

Comparing cases reported by ROM users and those not working with ROM, only differences related to the background was found, and ROM never featured in the descriptions of the feedback events.

How and when do therapists work with negative client feedback in ways that contribute constructively to the therapy process and/or their own professional development (Research question e)? The results suggest that specific feedback that is communicated directly to the therapist may increase therapists' ability to act on it. Improving the therapy process with dissatisfied clients may require flexibility and negotiation. Possibly, this is facilitated by therapists focusing on the client's contribution to the alliance problems while at the same time consciously regulating their own negative emotions elicited by the feedback. Therapists' internal attribution of the client's dissatisfaction, possibly combined with unregulated negative feelings towards themselves, may not necessarily be helpful to improve the subsequent therapy process. Lingering shame or guilt may however motivate the therapist to continue to reflect on their own contribution to the situation, and try out new ideas about what they can do differently with subsequent clients.

4 DISCUSSION

4.1 DISCUSSION OF FINDINGS

The principal aim of this thesis was to investigate variables that may influence and explain the effect of ROM on treatment outcomes, specifically client impairment levels, therapist differences, the working alliance, and therapists' reactions to negative feedback. The research presented here nuances our understanding of for whom, when, and how ROM works.

4.1.1 ROM improved treatment outcomes

ROM was found to improve overall treatment outcomes in Study 1. The overall effect size in favor of ROM was, however, the smallest reported in any PCOMS studies to date, d = 0.26. Other findings in this thesis could explain the low effect size, including the differences between therapists in their outcomes (the high ICCs) and the growth of ROM's effects over the duration of the trial.

Beyond demonstrating superior outcomes for ROM over TAU in a hospital mental health care setting, the main contribution of this thesis is the investigation of variables that might influence this effect, and the exploration of the process through which ROM influences outcomes. These topics will be discussed in the following.

4.1.2 No therapist variability in the overall effects of ROM

Unlike Anker et al. (2009), but similar to de Jong et al. (2012) and de Jong et al. (2014), in Paper I we found no significant variability between therapist in the impact of ROM on their clients' treatment outcomes. The interpretation of this finding is however uncertain due to the low number of therapists in Study 1 (N = 20) and the corresponding reduced statistical power (Schiefele et al., 2017). In a post. hoc analysis in Paper II, we found that therapists differed significantly in the influence of ROM on the alliance and the influence of the alliance on treatment outcomes. Although post. hoc findings should be interpreted with care, this suggests that therapists may differ in how they work with ROM to improve outcomes and specifically, that some may work more effectively with the alliance than others.

ROM did not reduce the variability between therapists in this sample; when controlling for the use of ROM, the proportion of variability in therapy outcomes accounted for by therapists (9%–10%) was slightly larger than that commonly reported in psychotherapy

studies (Baldwin & Imel, 2013). Consistent with this, the therapist effect has been found to be greater for more severe clients (Saxon & Barkham, 2012). The high variability between therapists in overall outcomes could explain the low overall effect size for ROM in Study 1; the pre-post effect size (d = 0.42) was substantially higher than the effect size obtained in the two-level model where therapist variability was controlled for (d = 0.26).

4.1.3 No influence of client impairment on the effects of ROM

This was the first study to find the PCOMS effective in a psychiatric population. The client sample in Study 1 was severely impaired, as indicated by mean initial ORS scores of 15, which is well below the clinical cutoff of 25 and the second lowest initial ORS scores reported in any PCOMS study (the lowest, 13.1, was reported in van Oenen et al., 2016). Moreover, in Paper I we found no influence of clients' impairment levels on the effects of ROM. To my knowledge only two other ROM studies have investigated initial impairment levels as moderators to ROM's effects; Hansson et al. (2013) found no difference in OQ effects for clients with low, medium and high initial impairment levels, but Amble, Gude, Ulvenes, et al. (2015) reported a near-significant trend towards better treatment outcomes with ROM for the more severely impaired clients.

If ROM works as well or better in highly impaired populations, then other variables might explain the null findings in PCOMS studies conducted in hospital mental health settings. For instance, in the group treatment study by Davidsen et al. (2017) the authors observed that therapists had very little flexibility to adjust the treatment according to the clients' feedback and consequently, the intervention may not have been used as intended. Similarly, in her doctoral thesis Rise (2012) suggested that non-optimal clinical implementation may explain the lack of a ROM effect reported in Rise et al. (2016). Thus, it is possible that the quality of implementation has as much or more influence on ROM's effects as the severity of the client's impairment.

However, there are some indications that ROM may have adverse effects for some groups of severely disturbed clients. Superior outcomes for TAU over ROM was reported in de Jong et al. (2017) and Errázuriz and Zilcha-Mano (2018) for non-progressing clients with cluster B personality disorders and several previous hospitalizations, respectively. Also, in van Oenen et al. (2016) mid-treatment outcomes were worse for ROM than TAU clients in emergency psychiatric care.

Thus, the conclusion in the review by Davidson et al. (2015) that ROM works better with less severely disturbed clients, although not supported by the findings in the present thesis, remains uncertain. Nevertheless, the superior effect for PCOMS in this highly impaired sample in itself challenges the notion that ROM is ineffective in severely impaired population. This is an important finding given the increasing interest in ROM. To date, most efforts to implement ROM in Norway have taken place in first-level treatment facilities. If replicated, our results indicate that these interventions may improve treatment also in hospital mental health care.

4.1.4 Increasing effects of ROM over time

In Paper I, we found that ROM's effects increased substantially over the duration of the trial, so that clients treated with ROM towards the end of the trial benefitted more from treatment than those treated with ROM in the beginning. To my knowledge, this is the first RCT to show increases in ROM effects over time; Davidsen et al. (2017) compared results in the first and second halves of their trial, and found no difference in ROM's effect.

We interpreded the growth in ROM's effects as a result of the continued implementation efforts that took place over the duration of the trial and particularly, the frequent ROM training and supervision that was provided. Similar increasing treatment effects for therapists working with ROM while continously trained and supervised in its use, was documented in two uncontrolled cases studies (Goldberg, Babins-Wagner, et al., 2016; Miller et al., 2006).

The training and supervision followed the principles delineated in the FIT manuals (Bertolini & Miller, 2012) as well as recommendations by Miller et al. (2015). That is, we prioritized discussing specific non-progressing cases. Diagnoses and therapeutic models were de-emphasized, and we focused on the client's experience of the working alliance. Therapists were encouraged to deliberately practice their therapeutic skills based on their clients' feedback. An overall goal was to foster a 'culture for feedback' (Bertolini & Miller, 2012) that valued clients' feedback and the critical evaluation of our own practices. However, as no attempts were made to assess the quality of implementation in this trial and no other implementation indicators were measured, this interpretation is uncertain.

This finding suggests that it may require some time and effort to develop an effective ROM program in a given treatment setting. The increasing ROM effect could also explain some of the variability in outcomes between studies; if ROM takes time and effort to

implement successfully, the overall effects would depend on both how well the intervention was implemented, and when during an implementation period outcomes were measured.

4.1.5 Mediation by the alliance of ROM's effects on outcomes

In Paper II, we found a significantly larger alliance increase from session one to two months' treatment in the ROM than TAU condition. This is consistent with previous ROM studies (Janse et al., 2017; McClintock et al., 2017) and suggests that systematically tracking clients' treatment responses may benefit the process of developing the collaborative working relationship in therapy. Possibly, this is especially true for ROM systems that contain alliance measures such as the SRS or the CSTs, although this was not specifically investigated in this study.

As the first ROM study to date, we further investigated whether the alliance increase predicted better outcomes in a way that could explain some of the superior effects of ROM on treatment outcomes (i.e., we tested a mediation hypothesis), and found this to be the case. Thus, data was consistent with a theory of the alliance as a mechanism through which some of the effects of ROM are transmitted (e.g., Miller et al., 2010). Possibly, the SRS helps therapists obtain feedback about alliance problems that they might otherwise have had problems obtaining (Macdonald & Mellor-Clark, 2014), and address these problems or in other ways change their behavior so as to improve the alliance, as suggested by feedback theory (Sapyta et al., 2005).

4.1.6 Characteristics of situations in which therapists changed their behavior following negative client feedback

The results of Study 2 indicated that that several factors may influence whether therapists are able to respond to negative feedback in ways that benefit their client or their own professional development. First, consistent with feedback theory (Sapyta et al., 2005), therapists learned from feedback that was actionable, i.e. contained information about therapist behaviors that they could control. In itself, the monitoring of clients' treatment responses through a ROM system provides only global feedback about the development of clients' symptoms or functioning over time, which may not be particularly actionable. Thus, the additional feedback about variables the therapist has some control over (e.g. the alliance) that is provided through, for instance, the PCOMS' SRS or the OQ system's CSTs, may

increase the likelihood that therapists will be able to respond constructively in non-progressing cases. Furthermore, the delivery of this feedback directly from the client to the therapist, such as is the case when clients complete the SRS within a treatment session, might have additional benefits.

Second, using negative client feedback to improve alliance problems may require sophisticated therapeutic skills. In general, ROM gives few guidelines about what therapists should do when being made aware that their client is dissatisfied with therapy, although some (e.g. the OQ system's Clinical Support Tools, CSTs; Lambert et al., 2007) are more instructive than others. There is a tendency in PCOMS writings to value the client's 'theory of change' above the therapist's and to recommend therapists to be cautious of 'blaming the client' when therapy fails (e.g., Duncan & Reese, 2015). This could be interpreted to mean that the therapist should go to some length to change according to the client's wishes. In our study however, the cases in which therapists attempted to do exactly as the client requested were not characterized by improved outcomes; these clients typically remained in therapy, but their dissatisfaction persisted, as did their therapists' shame and guilt. Instead, improved outcomes were typical in the cases in which therapists made a conscious effort to regulate their own negative emotions or countertransference reactions, invited the clients to examine the feedback together, negotiated with them in a flexible manner, and accommodated some of their requests without neither loosing nor stubbornly defending their own stance. This bears many similarities to the Rupture Repair Model by Safran and Muran (2000).

Third, the results support the notion that client feedback may facilitate therapist development, but that this may require some extra effort (Miller et al., 2015). Learning that extended beyond that particular situation was described in the cases in which therapists had received actionable feedback, but had not succeeded in repairing the alliance rupture. There were indications that these therapists had spent some time reflecting on the situation after the fact; they had several ideas about what they could have done differently, and described trying these new ideas out with subsequent clients. The changes that they had made in their ways of meeting new clients were tied to the content of the feedback they had received as well as their understanding of what went wrong in that particular instance and thus, differed considerably between cases. However, all behavior changes were connected to alliance work in some way or other. The ability to form strong alliances is a particularly important skills for therapists to develop (Miller et al., 2015); studies have found that most of the variability between therapists in outcomes was due to their ability to form and sustain helpful relationships with

diverse clients (e.g., Anderson, Ogles, Patterson, Lambert, & Vermeersch, 2009; Baldwin, Wampold, & Imel, 2007).

Forth, the results suggest that therapists' emotional reactions may influence their responses to negative feedback. In support of this, research has associated therapists' feelings towards their clients to treatment outcomes (e.g., Holmqvist, 2000a). We speculate that the other-directed emotions (e.g., irritation) that therapists reported experienced in the cases in which the alliance rupture was repaired, helped them maintain a focus on the client and how he or she contributed to the event. In contrast, in the cases in which therapists described learning that extended beyond that therapy, their self-directed emotions (e.g., shame or guilt) could have motivate both their giving in to the client's requests as well as their post-event reflection and their trying out of new ideas on subsequent clients. Interestingly, research has indicated both that certain client groups tend to evoke certain feelings in their therapists (Holmqvist, 1998, 2000b) and that therapists may have a personal feeling style across their different clients (Holmqvist, 2001). While this study was not designed to tease out the clients' and the therapists' relative contributions in these situations, it is notable that clients were presented as having relational difficulties and personality problems in the cases in which therapists responded with other-directed emotions, and as traumatized in the cases in which therapists responded with self-directed emotions.

4.2 DISCUSSION OF METHODS

4.2.1 Study 1: Randomized clinical trial

One of the strengths of the RCT was the implementation of a rigorous research methodology within the daily practice of a mental health center. Participation was mandatory for all employees at the clinic (i.e., the therapists were not selected based on interest, experience or skills) and clients were only excluded from participation if unable to execute the procedures required for the study. Consequently, we assume that both the client and therapist samples were representative for their respective populations, which should increase the external validity of findings. Nevertheless, a large proportion of all prospective client participants did not agree to participate. It cannot be ruled out that these clients differed from those who were included (e.g., by being more motivated or high-functioning), which could bias our findings.

A second strength of the study was that outcomes were assessed using different measures than the PCOMS' ORS and SRS, unlike most PCOMS studies published to date. This minimizes biases related to the properties of the instruments (e.g., non-optimal psychometric properties of the ORS and the SRS; Seidel & Miller, 2012) and increases the likelihood that the observed differences between condition are meaningful. However, the removal of two reversed-wording items from the WAI-S due to low item-total correlation, while increasing the internal consistency of the measure, could also bias our findings in Paper II. Also, the BASIS-32 has not been validated in a Norwegian population.

Like other ROM studies, the risk of performance and assessment bias was high. Neither therapists nor clients were blinded to the results of the randomization, and outcomes were assessed by client self-report. Blinding is difficult to achieve in ROM studies; by necessity therapists need to know whether or not to use ROM with a client. Also, similar to other ROM trials (Kendrick et al., 2016), the risk for attrition bias was high; for instance, about one third of all participants had missing data at post-treatment. Here, we dealt with the problem by utilizing a data analytic strategy that includes all available data (i.e. MLMs) rather than casewise deletion, and by imputing missing data points. Nevertheless, the high proportion of missing data implies that some caution should be exercised in generalizing our findings.

Other biases and threats to the generalizability of the findings include the training of therapists by ROM experts, time spent on implementation, and the use of computer scorings, which may not be equally accessible in all treatment settings. Also, one of PCOMS' developers, Scott D. Miller, was involved in this study as a clinical supervisor as well as a co-author in Paper II, which increases the risk of allegiance effects influencing our results. Therapist allegiance to ROM may also have influenced the observed differences in outcomes between conditions (Falkenström, Markowitz, Jonker, Philips, & Holmqvist, 2013); therapists' attitudes towards ROM were not assessed in the present research. On the other hand, it is probably inadvisable that any clinic implement ROM without any allegiance to the intervention and thus, our results may be generalizable to situations in which ROM proponents are involved in ROM implementation in a clinic which the employees are willing to work with ROM.

Due to some weaknesses in the design of the trial and the general difficulty in achieving experimental control of all variables in a practice setting, the interpretation of some of the findings in Study 1 is uncertain. These issues include the following: (1) low statistical power at the therapist level, with only 20 therapists, each treating between 1 and 19 clients

each; (2) the failure to measure any variables relevant for the quality of the clinical implementation of ROM, such as attitudes towards ROM, familiarity with the system, or 'feedback culture'; (3) the difficulty in establishing a clear time line in which the mediator was measured prior to the outcome and the potential confounding effect of the outcome variable on the mediator was controlled for (i.e., the direction of the alliance-outcome association cannot be determined in this trial); and (4) substantial therapist turnover over the course of the trial, with about one third of the client sample being treated by therapists who worked at the clinic for only parts of the data collection period. Regarding the latter point, in Paper I we obtained a very similar, although non-significant, estimate for the timing effect in a subsample consisting only of the cases that were treated by therapists who worked at the clinic throughout the entire trial. This supports the notion that the observed difference in ROM's effect over time was due to clinic-level changes rather than individual therapists learning to use ROM more effectively.

Finally, as this was not a dismantling study, we could not determine if the alliance tool SRS, the progress measure ORS, or both were responsible for the alliance growth that we observed in the ROM condition in Paper II. Also, PCOMS' procedure of administering ROM measures within the therapy session and discussing these scores with the client is not shared by all ROM systems and consequently, it is unclear if these findings are generalizable to those that are less explicitly focused on the alliance.

4.2.2 Study 2: Qualitative study

The purpose of the qualitative study was to explore a phenomenon in which there was little prior knowledge. As such, rather than providing knowledge that is generalizable to other populations, our aim was to describe the experience of receiving negative client feedback in a way that may be transferable to similar situations. It is however not clear if the processes indicated by this research are transferrable to working with ROM feedback. First, not all ROM systems encourage face-to-face discussions about the clients' experience of the therapy process in the way that the PCOMS does. Second, about half of the therapists in this sample reported working with ROM while the other half did not, but ROM never featured in the descriptions of the feedback events. One possible interpretation is that the feedback obtained through ROM is of a different character, perhaps more tied to specific aspects of the therapy process and thus, less salient and memorable, than the events that therapists chose to describe

when responding to the questions in this investigation. Thus, the relevance of our results to ROM is an open question requiring further research.

The study design, with therapist reported, written, retrospective accounts, further limits the conclusions that can be drawn from this study. The descriptions of the negative feedback situations were filtered through the therapists' perceptions, without any client data to fill in gaps or correct possible misrepresentations. More cases and richer descriptions of each case would have increased our confidence the in the results. Each participant described just one instance of negative feedback of their own choosing. Presumably these events were selected because they stood out in some way to the therapists, and we do not assume that they are representative for each particular therapist and also not for therapists in general.

5 CONCLUSIONS

With the methodological caveats in mind (as discussed above), the research presented in this thesis provides new knowledge relevant for understanding under what circumstances ROM might be expected to be effective and when it might not. Results indicates that the use of a ROM system such as the PCOMS can improve outcomes of mental health care in a population of relatively severely impaired clients. Successfully implementing ROM may however require some time and effort. Our results suggest that one of the effective elements within ROM may be improvements in the working alliance, although this finding is uncertain until replicated. Working with client feedback to improve alliance problems may require some skill on the part of the therapist; for instance, receiving negative feedback can elicit challenging emotions in therapists, which may make it difficult to respond constructively. Our results suggest that the process of translating insight gained from client feedback into behavior changes with new clients may require some effort. Possibly, this process is facilitated by a therapist's internal attribution of the client's dissatisfaction (i.e., the therapist believes that he or she, rather than the client, is responsible) and the accompanying negative self-directed emotions.

5.1 IMPLICATIONS FOR PRACTICE

Clinics considering implementing a ROM system are advised to develop an implementation plan where regular training and supervision are elements. One topic that might be addressed in training and supervision is how to use ROM feedback to identify and improve problems in the alliance. Therapists should be encouraged to openly discuss negative feedback (e.g. lack of progress in therapy, or dissatisfaction with the therapist) with clients, try out different strategies to solve alliance problems, and be flexible and willing to negotiate different ways of working together. In this negotiation, it might not always be necessary or advantageous to discard the therapist's strategy completely.

Furthermore, therapists' emotional reactions to negative feedback might be made a focus in ROM training and supervision. Therapists should be prepared that interacting with dissatisfied clients could prove challenging, and prepare ways of handling these situations, including regulating their own emotions. Strong feelings of shame or guilt could make it difficult to find a balance between assuming responsibility for problems in treatment while at the same time being conscious of possible contributions of those problems by the client's

interpersonal problems. Finally, therapists should be encouraged to reflect on their own role in unsuccessful therapies, develop ideas about what they can do differently, and try these out with new clients.

5.2 IMPLICATIONS FOR RESEARCH

This thesis explored several topics in which there is little prior research and as such, some of these findings await replications. This includes the lack of an impact of client impairment and ROM's effects, the development of ROM's effect over time, the mediation by the alliance, and the different ways in which therapists react and respond to negative feedback.

The question of *for whom* ROM improves outcomes is an important topic given previous indications of adverse effects of ROM for some clients (e.g., de Jong et al., 2017; Errázuriz & Zilcha-Mano, 2018). To better understand this, future research might investigate other client moderators than levels of symptoms and functioning, such as complexity or nature of clients' problems or their reflexive functioning.

The changing effect of ROM over time that was demonstrated in the present research emphasizes the need for more knowledge on *when* ROM is effective, i.e. what constitutes successful implementation of ROM, and how to achieve it. Another implication of this finding is that researchers investigating ROM in practice settings should assess whether the intervention has been sufficiently implemented before measuring its impact on therapy outcomes, and consider the timing of measurement when interpreting the results.

Better understanding *how* ROM works could help improve the clinical implementation of these interventions so that more clients benefit from their use. The mediation analysis presented here represents a first step towards understanding what the effective elements within ROM might be. More knowledge is needed on other processes that may be involved when therapists work with ROM. One of the major questions in ROM practice is how therapists should respond to negative feedback so as to avoid negative outcomes. The practice-based data bases that the use of ROM typically result in could provide opportunities to investigate this and other question with naturalistic data sets, for instance, by combining different research methodologies.

6 REFERENCES

Amble, I., Gude, T., Stubdal, S., Andersen, B. J., & Wampold, B. E. (2015). The effect of implementing the Outcome Questionnaire-45.2 feedback system in Norway: A multisite randomized clinical trial in a naturalistic setting. *Psychotherapy Research, 25*(6), 669-677.

Amble, I., Gude, T., Ulvenes, P., Stubdal, S., & Wampold, B. E. (2015). How and when feedback works in psychotherapy: Is it the signal? *Psychotherapy Research*, 1-11.

Anderson, T., Ogles, B. M., Patterson, C. L., Lambert, M. J., & Vermeersch, D. A. (2009). Therapist effects: Facilitative interpersonal skills as a predictor of therapist success. *Journal of Clinical Psychology, 65*(7), 755-768.

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.

Anseel, F., Beatty, A. S., Shen, W., Lievens, F., & Sackett, P. R. (2015). How are we doing after 30 years? A meta-analytic review of the antecedents and outcomes of feedback-seeking behavior. *Journal of Management, 41*(1), 318-348.

Baldwin, S. A., Berkeljon, A., Atkins, D. C., Olsen, J. A., & Nielsen, S. L. (2009). Rates of change in naturalistic psychotherapy: Contrasting dose–effect and good-enough level models of change. *Journal of Consulting and Clinical Psychology, 77*(2), 203-211.

Baldwin, S. A., & Imel, Z. E. (2013). Therapist effects: Findings and methods. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (6th ed., pp. 256-297). Hoboken, NJ: John Wiley & Sons.

Baldwin, S. A., Wampold, B. E., & Imel, Z. E. (2007). Untangling the alliance-outcome correlation: Exploring the relative importance of therapist and patient variability in the alliance. *Journal of Consulting and Clinical Psychology, 75*(6), 842.

Barkham, M., Connell, J., Stiles, W. B., Miles, J. N., Margison, F., Evans, C., & Mellor-Clark, J. (2006). Dose-effect relations and responsive regulation of treatment duration: the good enough level. *Journal of Consulting and Clinical Psychology, 74*(1), 160-167.

Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Beck depression inventory-II* (Vol. 78). San Antonio, TX: The Psychological Corporation.

Bertolini, B., & Miller, S. D. (2012). *ICCE Manuals on Feedback-Informed Treatment.* (Vol. 1-6). Chicago, IL: ICCE Press.

Bickman, L., Kelley, S. D., Breda, C., de Andrade, A. R., & Riemer, M. (2011). Effects of routine feedback to clinicians on mental health outcomes of youths: Results of a randomized trial. *Psychiatric Services, 62*(12), 1423-1429.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice, 16*(3), 252.

Boswell, J. F., Kraus, D. R., Miller, S. D., & Lambert, M. J. (2015). Implementing routine outcome monitoring in clinical practice: Benefits, challenges, and solutions. *Psychotherapy Research, 25*(1), 6-19.

Boulet, J., & Boss, M. W. (1991). Reliability and validity of the Brief Symptom Inventory. *Psychological Assessment: A Journal of Consulting and Clinical Psychology, 3*(3), 433-437.

Busseri, M. A., & Tyler, J. D. (2003). Interchangeability of the working alliance inventory and working alliance inventory, short form. *Psychological Assessment, 15*(2), 193-197.

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.

Claiborn, C. D., & Goodyear, R. K. (2005). Feedback in psychotherapy. *Journal of Clinical Psychology, 61*(2), 209-217.

Cooper, Z., & Fairburn, C. (1987). The eating disorder examination: A semi‐structured interview for the assessment of the specific psychopathology of eating disorders. *International Journal of Eating Disorders, 6*(1), 1-8.

Coutinho, J., Ribeiro, E., Hill, C., & Safran, J. (2011). Therapists' and clients' experiences of alliance ruptures: a qualitative study. *Psychotherapy Research, 21*(5), 525-540.

Davidsen, A., Poulsen, S., Lindschou, J., Winkel, P., Tróndarson, M., Waaddegaard, M., & Lau, M. (2017). Feedback in group psychotherapy for eating disorders: A randomized clinical trial. *Journal of Consulting and Clinical Psychology, 88*(1), 484-494. doi:10.1037/ccp0000173.

Davidson, K., Perry, A., & Bell, L. (2015). Would continuous feedback of patient's clinical outcomes to practitioners improve NHS psychological therapy services? Critical analysis and assessment of quality of existing studies. *Psychology and Psychotherapy: Theory, Research and Practice, 88*(1), 21-37.

de Jong, K. (2016). Deriving implementation strategies for outcome monitoring feedback from theory, research and practice. *Administration and Policy in Mental Health and Mental Health Services Research, 43*(3), 292-296. doi:10.1007/s10488-014-0589-6

de Jong, K., & De Goede, M. (2015). Why do some therapists not deal with outcome monitoring feedback? A feasibility study on the effect of regulatory focus and person–organization fit on attitude and outcome. *Psychotherapy Research, 25*(6), 661-668.

de Jong, K., Segaar, J., Ingenhoven, T., van Busschbach, J., & Timman, R. (2017). Adverse Effects of Outcome Monitoring Feedback in Patiens With Personality Disorders: A Randomized Controlled Trial in Day Treatment and Inpatient Settings. *Journal of Personality Disorders*, Advance online publication. doi:10.1521/pedi_2017_31_297

de Jong, K., Timman, R., Hakkaart-Van Roijen, L., Vermeulen, P., Kooiman, K., Passchier, J., & Busschbach, J. V. (2014). The effect of outcome monitoring feedback to clinicians and patients in short and long-term psychotherapy: A randomized controlled trial. *Psychotherapy Research, 24*(6), 629-639.

de Jong, K., van Sluis, P., Nugter, M. A., Heiser, W. J., & Spinhoven, P. (2012). Understanding the differential impact of outcome monitoring: Therapist variables that moderate feedback effects in a randomized clinical trial. *Psychotherapy Research, 22*(4), 464-474.

Derogatis, L. R. (1992). *SCL-90-R: Administration, Scoring & Procedures Manual-II for the Revised Version and Other Instruments of the Psychopathology Rating Scale Series*. Baltimore, MD: Clinical Psychometric Research.

Douglas, S. R., Jonghyuk, B., de Andrade, A. R. V., Tomlinson, M. M., Hargraves, R. P., & Bickman, L. (2015). Feedback mechanisms of change: How problem alerts reported by youth clients and their caregivers impact clinician-reported session content. *Psychotherapy Research, 25*(6), 678-693.

Duncan, B. L., Miller, S. D., Sparks, J. A., Claud, D. A., Reynolds, L. R., Brown, J., & Johnson, L. D. (2003). The Session Rating Scale: Preliminary psychometric properties of a “working” alliance measure. *Journal of Brief Therapy, 3*(1), 3-12.

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.

Eisen, S. V., Wilcox, M., Leff, H. S., Schaefer, E., & Culhane, M. A. (1999). Assessing behavioral health outcomes in outpatient programs: Reliability and validity of the BASIS-32. *The Journal of Behavioural Health Services & Research, 26*(1), 5-17.

Ericsson, K. A., Hoffman, R. R., Kozbelt, A., & Williams, A. M. (2018). *The Cambridge handbook of expertise and expert performance*. Cambridge, UK: Cambridge University Press.

Errázuriz, P., & Zilcha-Mano, S. (2018). In psychotherapy with severe patients discouraging news may be worse than no news: The impact of providing feedback to therapists on psychotherapy outcome, session attendance, and the alliance. *Journal of Consulting and Clinical Psychology, 86*(2), 125-139.

Falkenström, F., Ekeblad, A., & Holmqvist, R. (2016). Improvement of the working alliance in one treatment session predicts improvement of depressive symptoms by the next session. *Journal of Consulting and Clinical Psychology, 84*(8), 738-751.

Falkenström, F., Granström, F., & Holmqvist, R. (2013). Therapeutic alliance predicts symptomatic improvement session by session. *Journal of Counseling Psychology, 60*(3), 317-328.

Falkenström, F., Markowitz, J. C., Jonker, H., Philips, B., & Holmqvist, R. (2013). Can psychotherapists function as their own controls? Meta-analysis of the "crossed therapist" design in comparative psychotherapy trials. *The Journal of clinical psychiatry, 74*(5), 482-491.

Field, A. (2013). *Discovering statistics using IBM SPSS Statistics* (4 ed.). London, UK: SAGE Publications Ltd.

Fixsen, D. L., Blase, K. A., Naoom, S. F., & Wallace, F. (2009). Core implementation components. *Research on Social Work Practice, 19*(5), 531-540.

Gibbons, M. B. C., Kurtz, J. E., Thompson, D. L., Mack, R. A., Lee, J. K., Rothbard, A., . . . Crits-Christoph, P. (2015). The effectiveness of clinician feedback in the treatment of depression in the community mental health system. *Journal of Consulting and Clinical Psychology, 83*(4), 748-759.

Goldberg, S. B., Babins-Wagner, R., Rousmaniere, T., Berzins, S., Hoyt, W. T., Whipple, J. L., . . . Wampold, B. E. (2016). Creating a climate for therapist improvement: A case study of an agency focused on outcomes and deliberate practice. *Psychotherapy, 53*(3), 367-375.

Goldberg, S. B., Rousmaniere, T., Miller, S. D., Whipple, J., Nielsen, S. L., Hoyt, W. T., & Wampold, B. E. (2016). Do psychotherapists improve with time and experience? A longitudinal analysis of outcomes in a clinical setting. *Journal of Counseling Psychology, 63*(1), 1-11.

Gondek, D., Edbrooke-Childs, J., Fink, E., Deighton, J., & Wolpert, M. (2016). Feedback from Outcome Measures and Treatment Effectiveness, Treatment Efficiency, and Collaborative Practice: A Systematic Review. *Administration and Policy in Mental Health and Mental Health Services Research, 43*(3), 325-343. doi:10.1007/s10488-015-0710-5

Green, H., Barkham, M., Kellett, S., & Saxon, D. (2014). Therapist effects and IAPT psychological wellbeing practitioners (PWPs): a multilevel modelling and mixed methods analysis. *Behaviour research and therapy, 63*, 43-54.

Hamaker, E. L., & Klugkist, I. (2011). Bayesian Estimation of Multilevel Models. In J. Hox & J. K. Roberst (Eds.), *Handbook of advanced multilevel analysis*. Hove, UK: Psychology Press.

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.

Hansen, N. B., & Lambert, M. J. (2003). An evaluation of the dose–response relationship in naturalistic treatment settings using survival analysis. *Mental Health Services Research, 5*(1), 1-12.

Hansen, N. B., Lambert, M. J., & Forman, E. M. (2002). The psychotherapy dose‐response effect and its implications for treatment delivery services. *Clinical Psychology: Science and Practice, 9*(3), 329-343.

Hanson, W. E., Curry, K. T., & Bandalos, D. L. (2002). Reliability generalization of working alliance inventory scale scores. *Educational and Psychological Measurement, 62*(4), 659-673.

Hansson, H., Rundberg, J., Österling, A., Öjehagen, A., & Berglund, M. (2013). Intervention with feedback using Outcome Questionnaire 45 (OQ-45) in a Swedish psychiatric outpatient population. A randomized controlled trial. *Nordic Journal of Psychiatry, 67*(4), 274-281.

Hatcher, R. L., & Barends, A. W. (2006). How a return to theory could help alliance research. *Psychotherapy: Theory, Research, Practice, Training, 43*(3), 292-299.

Hatcher, R. L., & Gillaspy, J. A. (2006). Development and validation of a revised short version of the Working Alliance Inventory. *Psychotherapy Research, 16*(1), 12-25.

Hatfield, D., McCullough, L., Frantz, S. H., & Krieger, K. (2010). Do we know when our clients get worse? An investigation of therapists' ability to detect negative client change. *Clinical Psychology & Psychotherapy, 17*(1), 25-32.

Hawkins, E. J., Lambert, M. J., Vermeersch, D. A., Slade, K. L., & Tuttle, K. C. (2004). The therapeutic effects of providing patient progress information to therapists and patients. *Psychotherapy Research, 14*(3), 308-327.

Helsedirektoratet. (2014). *Sammen for mestring - Veileder i lokalt psykisk helsearbeid og rusarbeid hos voksne*. Retrieved from https://helsedirektoratet.no/retningslinjer/sammen-om-mestring-veileder-i-lokalt-psykisk-helsearbeid-og-rusarbeid-for-voksne.

Helsedirektoratet. (2017). *Nasjonal faglig retningslinje for behandling og rehabilitering av rusmiddelproblemer og avhengighet*. Retrieved from https://helsedirektoratet.no/retningslinjer/behandling-og-rehabilitering-av-rusmiddelproblemer-og-avhengighet.

Hill, C. E. (2012). *Consensual qualitative research: A practical resource for investigating social science phenomena*: American Psychological Association.

Hill, C. E., Kellems, I. S., Kolchakian, M. R., Wonnell, T. L., Davis, T. L., & Nakayama, E. Y. (2003). The therapist experience of being the target of hostile versus suspected-unasserted client anger: Factors associated with resolution. *Psychotherapy Research, 13*(4), 475-491.

Hill, C. E., Knox, S., Thompson, B. J., Williams, E. N., Hess, S. A., & Ladany, N. (2005). Consensual qualitative research: An update. *Journal of Counseling Psychology, 52*(2), 196.

Hill, C. E., Nutt-Williams, E., Heaton, K. J., Thompson, B. J., & Rhodes, R. H. (1996). Therapist retrospective recall impasses in long-term psychotherapy: A qualitative analysis. *Journal of Counseling Psychology, 43*(2), 207.

Holmqvist, R. (1998). The influence of patient diagnosis and self-image on clinicians' feelings. *J Nerv Ment Dis, 186*(8), 455-461.

Holmqvist, R. (2000a). Associations between staff feelings toward patients and treatment outcome at psychiatric treatment homes. *Journal of Nervous and Mental Disease, 188*(6), 366-371.

Holmqvist, R. (2000b). Staff feelings and patient diagnosis. *The Canadian Journal of Psychiatry, 45*(4), 349-356.

Holmqvist, R. (2001). Patterns of consistency and deviation in therapists' countertransference feelings. *The Journal of Psychotherapy Practice and Research, 10*(2), 104-116.
Holmqvist, R., Hansjons‐Gustafsson, U., & Gustafsson, J. (2002). Patients' relationship episodes and therapists' feelings. *Psychology and Psychotherapy: Theory, Research and Practice, 75*(4), 393-409.
Holmqvist, R., Philips, B., & Barkham, M. (2015). Developing practice-based evidence: Benefits, challenges, and tensions. *Psychotherapy Research, 25*(1), 20-31.
Horvath, A. O. (1994). *Empirical validation of Bordin's pantheoretical model of the alliance: The Working Alliance Inventory perspective*. New York: Wiley.
Horvath, A. O., & Bedi, R. P. (2002). The alliance. In C. Norcross (Ed.), *Psychotherapy Relationships that Work: Therapist Contributions and Responsiveness* (pp. 37-69). London: Oxford University Press.
Horvath, A. O., Del Re, A. C., Flückiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy, 48*(1), 9-16.
Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology, 36*(2), 223.
Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology, 38*(2), 139-149.
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.
Howard, K. I., Moras, K., Brill, P. L., Martinovich, Z., & Lutz, W. (1996). Evaluation of psychotherapy: Efficacy, effectiveness, and patient progress. *American Psychologist, 51*(10), 1059-1064.
Janse, P. D., De Jong, K., Van Dijk, M. K., Hutschemaekers, G. J., & Verbraak, M. J. (2017). Improving the efficiency of cognitive-behavioural therapy by using formal client feedback. *Psychotherapy Research, 27*(5), 525-538. doi:10.1080/10503307.2016.1152408
Kendrick, T., El-Gohary, M., Stuart, B., Gilbody, S., Churchill, R., Aiken, L., . . . 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*(7), 1-108. doi:10.1002/14651858.CD011119.pub2
Kenny, D. A., Korchmaros, J. D., & Bolger, N. (2003). Lower level mediation in multilevel models. *Psychological methods, 8*(2), 115-128.
Kivlighan Jr, D. M., & Shaughnessy, P. (2000). Patterns of working alliance development: A typology of client's working alliance ratings. *Journal of Counseling Psychology, 47*(3), 362-371.
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.
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.
Lambert, M. J. (1992). Psychotherapy outcome research: Implications for integrative and eclectical therapists. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (pp. 94-129). New York: Basic Books.
Lambert, M. J. (2004). *Administration and Scoring Manual for the OQ-45.2 (Outcome Questionnaire)*. Wilmington, DE: American Professional Credentialing Services.
Lambert, M. J. (2007). Presidential address: What we have learned from a decade of research aimed at improving psychotherapy outcome in routine care. *Psychotherapy Research, 17*(1), 1-14.

Lambert, M. J. (2010). Yes, it is time for clinicans to routinely monitor treatment outcome. In B. Duncan, S. D. Miller, B. E. Wampold, & M. Hubble (Eds.), *The heart and soul of change: Delivering what works in therapy*. Washington, DC: American Psychological Association.

Lambert, M. J. (2015). Progress feedback and the OQ-system: The past and the future. *Psychotherapy, 52*(4), 381-390.

Lambert, M. J., Bailey, R., Kimball, K., Shimokawa, K., Harmon, S. C., & Slade, K. (2007). Clinical support tools manual-brief version-40. *Salt Lake City: OQ Measures*.

Lambert, M. J., & Ogles, B. M. (2004). The efficacy and effectiveness of psychotherapy. In M. Lambert (Ed.), *Bergin and Garfields Handbook of Psychotherapy and Behavior Change* (5 ed., pp. 139-193). New York: Wiley.

Lambert, M. J., & Shimokawa, K. (2011). Collecting client feedback. *Psychotherapy, 48*(1), 72-79.

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.

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.

Lucock, M., Halstead, J., Leach, C., Barkham, M., Tucker, S., Randal, C., . . . Waters, E. (2015). A mixed-method investigation of patient monitoring and enhanced feedback in routine practice: Barriers and facilitators. *Psychotherapy Research, 25*(6), 633-646.

Lutz, W., De Jong, K., & Rubel, J. (2015). Patient-focused and feedback research in psychotherapy: Where are we and where do we want to go? *Psychotherapy Research, 25*(6), 625-632.

Macdonald, J., & Mellor-Clark, J. (2014). Correcting Psychotherapists' Blindsidedness: Formal Feedback as a Means of Overcoming the Natural Limitations of Therapists. *Clinical Psychology & Psychotherapy, 22*(3), 249-257.

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: a meta-analytic review. *Journal of Consulting and Clinical Psychology, 68*(3), 438-450.

McClintock, A. S., Perlman, M. R., McCarrick, S. M., Anderson, T., & Himawan, L. (2017). Enhancing psychotherapy process with common factors feedback: A randomized, clinical trial. *Journal of Counseling Psychology, 64*(3), 247-260.

Mellor-Clark, J., Cross, S., Macdonald, J., & Skjulsvik, T. (2016). Leading horses to water: Lessons from a decade of helping psychological therapy services use routine outcome measurement to improve practice. *Administration and Policy in Mental Health and Mental Health Services Research, 43*(3), 279-285. doi:10.1007/s10488-014-0587-8

Mikeal, C. W., Gillaspy Jr., 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. doi:10.1037/cou0000168

Miller, S. D., Duncan, B. L., Brown, J., Sorrell, R., & Chalk, M. B. (2006). Using formal client feedback to improve retention and outcome: Making ongoing, real-time assessment feasible. *Journal of Brief Therapy, 5*(1), 5-22.

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*(2), 91-100.

Miller, S. D., Duncan, B. L., Sorrell, R., & Brown, G. S. (2005). The partners for change outcome management system. *Journal of Clinical Psychology, 61*(2), 199-208.

Miller, S. D., Hubble, M. A., Chow, D., & Seidel, J. (2015). Beyond measures and monitoring: Realizing the potential of feedback-informed treatment. *Psychotherapy, 52*(4), 449-457.

Miller, S. D., Hubble, M. A., Duncan, B. L., & Wampold, B. E. (2010). Delivering what works. In B. L. Duncan, S. D. Miller, B. E. Wampold, & M. A. Hubble (Eds.), *The Heart and Soul of Change: Delivering What Works in Therapy* (2 ed.). Washington, D.C.: American Psychological Association.

Mohr, D. C. (1995). Negative outcome in psychotherapy: A critical review. *Clinical Psychology: Science and Practice, 2*(1), 1-27.

Moltu, C., Binder, P.-E., & Nielsen, G. H. (2010). Commitment under pressure: Experienced therapists' inner work during difficult therapeutic impasses. *Psychotherapy Research, 20*(3), 309-320.

Murphy, K. P., Rashleigh, C. M., & Timulak, L. (2012). The relationship between progress feedback and therapeutic outcome in student counselling: A randomised control trial. *Counselling Psychology Quarterly, 25*(1), 1-18.

Oanes, C. J., Anderssen, N., Karlsson, B., & Borg, M. (2015). How do therapists respond to client feedback? A critical review of the research literature. *Scandinavian Psychologist, 2*.

Oanes, C. J., Karlsson, B., & Borg, M. (2017). User Involvement in Therapy: Couples' and Family Therapists' Lived Experiences with the Inclusion of a Feedback Procedure in Clinical Practice. *Australian and New Zealand Journal of Family Therapy, 38*(3), 451-463.

Okiishi, J., Lambert, M. J., Eggett, D., Nielsen, L., Dayton, D. D., & Vermeersch, D. A. (2006). An analysis of therapist treatment effects: Toward providing feedback to individual therapists on their clients' psychotherapy outcome. *Journal of Clinical Psychology, 62*(9), 1157-1172.

Okiishi, J., Lambert, M. J., Nielsen, S. L., & Ogles, B. M. (2003). Waiting for supershrink: An empirical analysis of therapist effects. *Clinical Psychology & Psychotherapy, 10*(6), 361-373.

Helse- og omsorgsdepartementet (2017). *Mestre hele livet. Regjeringens strategi for god psykisk helse (2017-2022)*. Retrieved from https://www.regjeringen.no/no/dokumenter/mestre-hele-livet/id2568354/.

Owen, J., Miller, S. D., Seidel, J., & Chow, D. (2016). The Working Alliance in Treatment of Military Adolescents. *Journal of Consulting and Clinical Psychology*.

Probst, T., Lambert, M. J., Loew, T. H., Dahlbender, R. W., Göllner, R., & Tritt, K. (2013). Feedback on patient progress and clinical support tools for therapists: Improved outcome for patients at risk of treatment failure in psychosomatic in-patient therapy under the conditions of routine practice. *Journal of Psychosomatic Research, 75*(3), 255-261.

Puschner, B., Schöfer, D., Knaup, C., & Becker, T. (2009). Outcome management in in-patient psychiatric care. *Acta Psychiatrica Scandinavica, 120*(4), 308-319.

Reese, R. J., Gillaspy, J. A., Owen, J. J., Flora, K. L., Cunningham, L. C., Archie, D., & Marsden, T. (2013). The influence of demand characteristics and social desirability on clients' ratings of the therapeutic alliance. *Journal of Clinical Psychology, 69*(7), 696-709.

Reese, R. J., Norsworthy, L. A., & Rowlands, S. R. (2009a). Does a continuous feedback system improve psychotherapy outcome? *Psychotherapy: Theory, Research, Practice, Training, 46*(4), 418-431.

Reese, R. J., Norsworthy, L. A., & Rowlands, S. R. (2009b). Does a continuous feedback system improve psychotherapy outcome? *Psychotherapy: Theory, Research, Practice, Training, 46*(4), 418-431.

Reese, R. J., Toland, M. D., Slone, N. C., & Norsworthy, L. A. (2010). Effect of client feedback on couple psychotherapy outcomes. *Psychotherapy: Theory, Research, Practice, Training, 47*(4), 616-630.

Rise, M. B. (2012). *Lifting the veil from user participation in clinical work–What is it and does it work?* (Doctoral thesis). The Norwegian University of Science and Technology.

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), 348-360.

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.

Robert, C. (2007). *The Bayesian Choice: From Decision-Theoretic Foundations to Computational Implementation*. New York, NY: Springer Science & Business Media.

Ronnestad, M. H., & Skovholt, T. M. (2003). The journey of the counselor and therapist: Research findings and perspectives on professional development. *Journal of Career Development, 30*(1), 5-44.

Ronnestad, M. H., & Skovholt, T. M. (2012). *The Developing Practitioner: Growth and Stagnation of Therapists and Counselors*. Abingdon, UK: Routledge.

Safran, J. D., & Muran, J. C. (2000). *Negotiating the Therapeutic Alliance: A Relational Treatment Guide*. New York, NY: Guilford Press.

Safran, J. D., & Muran, J. C. (2006). Has the concept of the therapeutic alliance outlived its usefulness? *Psychotherapy: Theory, Research, Practice, Training, 43*(3), 286-291.

Safran, J. D., Muran, J. C., & Eubanks-Carter, C. (2011). Repairing alliance ruptures. *Psychotherapy (Chic), 48*(1), 80-87. doi:10.1037/a0022140

Sapyta, J., Riemer, M., & Bickman, L. (2005). Feedback to clinicians: Theory, research, and practice. *Journal of Clinical Psychology, 61*(2), 145-153.

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.

Saxon, D., Barkham, M., Foster, A., & Parry, G. (2017). The contribution of therapist effects to patient dropout and deterioration in the psychological therapies. *Clinical Psychology & Psychotherapy, 24*(3), 575-588.

Schiefele, A.-K., Lutz, W., Barkham, M., Rubel, J., Böhnke, J., Delgadillo, J., . . . Nielsen, S. L. (2017). Reliability of therapist effects in practice-based psychotherapy research: A guide for the planning of future studies. *Administration and Policy in Mental Health and Mental Health Services Research, 44*(5), 598-613.

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. *Psychotherapy Research, 25*(4), 396-407.

Seidel, J., & Miller, S. D. (2012). Manual 4: Documenting change: A primer on measurement, analysis, and reporting. In B. Bertolini & S. D. Miller (Eds.), *The ICCE Manuals on Feedback-Informed Treatment (FIT)*. Chicago, IL: International Center for Clinical Excellence.

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.

Simon, W., Lambert, M. J., Busath, G., Vazquez, A., Berkeljon, A., Hyer, K., . . . Berrett, M. (2013). Effects of providing patient progress feedback and clinical support tools to psychotherapists in an inpatient eating disorders treatment program: A randomized controlled study. *Psychotherapy Research, 23*(3), 287-300.

Simon, W., Lambert, M. J., Harris, M. W., Busath, G., & Vazquez, A. (2012). Providing patient progress information and clinical support tools to therapists: Effects on patients at risk of treatment failure. *Psychotherapy Research, 22*(6), 638-647.

Slone, N. C., Reese, R. J., Mathews-Duvall, S., & Kodet, J. (2015). Evaluating the efficacy of client feedback in group psychotherapy. *Group Dynamics: Theory, Research, and Practice, 19*(2), 122-136. doi:10.1037/gdn0000026

Snyder, J., & Aafjes-van Doorn, K. (2016). Utilizing measure-based feedback in control-mastery theory: A clinical error. *Psychotherapy, 53*(3), 291-296.

Stulz, N., Lutz, W., Leach, C., Lucock, M., & Barkham, M. (2007). Shapes of early change in psychotherapy under routine outpatient conditions. *Journal of Consulting and Clinical Psychology, 75*(6), 864-874.

Sundet, R. (2012). Therapist perspectives on the use of feedback on process and outcome: Patient-focused research in practice. *Canadian Psychology/Psychologie canadienne, 53*(2), 122-130. doi:10.1037/a0027776

Sundet, R. (2014). Patient‐focused research supported practices in an intensive family therapy unit. *Journal of Family Therapy, 36*(2), 195-216.

Tracey, T. J., & Kokotovic, A. M. (1989). Factor structure of the Working Alliance Inventory. *Psychological Assessment: A Journal of Consulting and Clinical Psychology, 1*(3), 207-210.

Tracey, T. J., Wampold, B. E., Lichtenberg, J. W., & Goodyear, R. K. (2014). Expertise in psychotherapy: An elusive goal? *American Psychologist, 69*(3), 218.

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), 110-122. doi:10.1186/s12888-016-0811-z

Wampold, B. E. (2015). Routine outcome monitoring: Coming of age—With the usual developmental challenges. *Psychotherapy, 52*(4), 458-462. doi:10.1037/pst0000037

Wampold, B. E., & Imel, Z. E. (2015). *The great psychotherapy debate* (2 ed.). New York, NY: Routledge.

Whipple, J. L., Lambert, M. J., Vermeersch, D. A., Smart, D. W., Nielsen, S. L., & Hawkins, E. J. (2003). Improving the effects of psychotherapy: The use of early identification of treatment and problem-solving strategies in routine practice. *Journal of Counseling Psychology, 50-68*(1), 59-68.

Willis, A., Deane, F. P., & Coombs, T. (2009). Improving clinicians' attitudes toward providing feedback on routine outcome assessments. *International Journal of Mental Health Nursing, 18*(3), 211-215.

Wolpert, M. (2014). Uses and abuses of Patient Reported Outcome Measures (PROMs): Potential iatrogenic impact of PROMs implementation and how it can be mitigated. *Administration and Policy in Mental Health and Mental Health Services Research, 41*(2), 141-145.

Zilcha-Mano, S., & Errázuriz, P. (2015). One size does not fit all: Examining heterogeneity and identifying moderators of the alliance–outcome association. *Journal of Counseling Psychology, 62*(4), 579-591.

7 APPENDIX

THE NEGATIVE CLIENT FEEDBACK QUESTIONNAIRE

A. Questions about you as a therapist

1. How much would you say that the following psychotherapeutic models have influenced your understanding and treatment of clients? *(1. Psychodynamic – 2. Cognitive/behavioral – 3. Humanistic/existential – 4. Other, please describe)*
2. How confident do you feel as a therapist? *(1. Not at all – 2. A little – 3. Quite – 4. Very)*
3. Do you work with the Partners for Change Outcome Monitoring System (PCOMS)? *(1. Never – 2. With some clients – 3. With most clients – 4. Always)*
4. If you work with the PCOMS: How long have you done so?
5. How concerned are you with your clients' views of you as a therapist and the way that you work? *(1. Not at all – 2. A little – 3. Quite – 4. Very)*
6. How frequently do you receive feedback from your clients about their experiences of you as a therapist or the way you work together with them? *(1. Daily – 2. Weekly – 3. Monthly – 5. Less than monthly – 6. Never)*
7. Do you do anything to facilitate conversations with your clients about their experiences of treatment and their relationship to you? Please explain.
8. What kind of feedback do you receive from your clients? What are your thoughts about this?

B. Questions about the feedback event

Please think back and see if you can remember a situation in which you received negative feedback from a client about you as a therapist or about the treatment.

Background:

9. Please describe the clients' reasons for seeking help, and his or her goals in therapy. What was your understanding of and approach with this client?
10. How would you describe your relationship to this client before the feedback event? Had the client benefitted from working with you?
11. Are there any other things you can tell us about the background to the feedback event?

The feedback event:

12. What was the feedback, and how was it communicated?
13. How did you react? What were your thoughts? What did you feel? What did you do?
14. How did the client react to your response to the feedback? How do you think the client experienced the situation?
15. Are there any other things that you can tell us about the situation?

Your understanding of the feedback event:

16. How did you understand the client's feedback?
17. Why do you think you reacted the way you did?
18. Was this event unusual, or was it similar to other experiences you'd had before? In what way?
19. Are there any other things you can tell us about your understanding of the event?

Consequences of the feedback event:

20. How did the therapy develop following the feedback event?
21. Has the experience had an influence on you as a therapist and your work with other clients? How so?
22. If you experienced something similar now, would you do anything differently? If so, what?
23. Are there any other things you can tell us about the consequences of this event?

8. ORIGINAL PAPERS I - III

Paper I

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Learning from clients: A qualitative investigation of psychotherapists' reactions to negative verbal feedback

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EMPIRICAL PAPER

Learning from clients: A qualitative investigation of psychotherapists' reactions to negative verbal feedback*

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Objective: To explore how therapists experience, react to, and learn from negative feedback from their clients. **Method:** Eighteen experienced therapists' written descriptions of episodes where they had received negative verbal feedback from clients were analyzed according to the Consensual Qualitative Research methodology. **Results:** Receiving feedback was experienced as challenging, but educational. Learning was manifested in different ways: (a) Immediately Applied Learning—therapists improved the following therapy process by changing their behavior with the client, (b) Retrospectively Applied Learning—therapists made changes in their way of working with subsequent clients, and (c) Non-Applied Learning—new ideas generated by the experience had not been translated into behavior. We compared cases describing these manifestations of learning and found differences in the nature of the feedback and how therapists understood, reacted, and responded to it. **Conclusions:** The therapists benefitted from obtaining and being open to specific feedback from their clients, regulating their own emotional reactions, accommodating dissatisfied clients, and considering how they themselves contributed to negative therapy processes.

Keywords: alliance; psychotherapist training/supervision/development; process research; qualitative research methods; client feedback; therapist difficulties

The relationship between psychotherapists' experience and expertise is not clear. In general, therapists have a sense of continually evolving as a result of their work with clients and in particular, information that they gain from clients' reactions to their actions (Ronnestad & Skovholt, 2003, 2012), but evidence for differences in actual outcomes between more and less experienced therapists is mixed (Beutler et al., 2004; Tracey, Wampold, Lichtenberg, & Goodyear, 2014). In the first longitudinal study of its kind, Goldberg et al. (2016) analyzed 170 therapists' outcomes with more than 5500 clients over the average of almost 5 years. At a group level these therapists' effect sizes were found to *decrease* slightly as they became more experienced, although almost 40% of the sample did improve their results over time. Discussing their results, the authors commented that the quality of experience might be more important for learning than the quantity and that therapists' deliberate efforts, such as practicing skills based on performance feedback, might facilitate their professional development. They observed however that conditions necessary to do so are typically not present in most practice settings. When

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and how do therapists learn from experience, and in particular, from corrective or negative feedback from their clients?

Feedback is defined as "a response to an action that shapes or adjusts that action in subsequent performance" (Claiborn & Goodyear, 2005, p. 209). The present investigation focuses on verbally expressed negative feedback that prompt a change in the therapist, that is, that he or she learns from. This is a broader conceptualization of feedback than what has typically been the case within the patient-focused research paradigm (Howard, Moras, Brill, Martinovich, & Lutz, 1996), where client feedback often is used synonymous to information obtained through regularly administered measures of clients' treatment responses (Routine Outcome Monitoring [ROM]; see, for instance, Lambert, 2007). Although researchers are beginning to explore the potential of these interventions as learning tools for therapists (Miller, Hubble, Chow, & Seidel, 2015), they represent a relatively new development in psychotherapy and it is likely that also less formal feedback from clients facilitate therapists' professional development. Psychodynamic models offer valuable perspectives on situations where negative verbal feedback from clients typically occurs, such as impasses, ruptures, or breaches in the therapeutic alliance (see, for instance, Hill & Knox, 2009). Here, however, the emphasis is different: How therapists' behavior is affected by the negative feedback rather than why the client is dissatisfied (e.g., transference, defense mechanisms), why the therapist reacts as he or she does (e.g., countertransference), or how the therapist can respond in a way that helps the client (e.g., repair ruptures, provide insight or corrective experiences).

While it is unclear why not all therapists improve their ability to help clients as they become more experienced, some obstacles to learning from experience are suggested in the literature. A first barrier is that it can be hard for therapists to obtain clear and unambiguous feedback about how they are doing. Many clients find it difficult to express dissatisfaction and instead choose to conceal negative feelings about therapy or the therapist (Blanchard & Farber, 2015; Farber, 2003). Therapists are frequently not aware of what their clients leave unsaid (Hill, Thompson, Cogar, & Denman, 1993; Hill, Thompson, & Corbett, 1992; Regan & Hill, 1992). As a result, therapists may have restricted access to the kind of feedback that according to feedback theory (Sapyta, Riemer, & Bickman, 2005) is most likely to motivate them to change: Immediately and frequently delivered after a given behavior and containing new and specific information about that behavior.

A second barrier to learning from feedback is the therapists' covert reactions to negative appraisal, or " the enormous difficulty that human beings, even highly trained therapists, have in dealing with interpersonal conflict in which they are participants" (Binder & Strupp, 1997, p. 123). Therapists have disclosed feelings of guilt, anxiety, incompetence, confusion, and irritation when confronted with their clients' dissatisfaction in several qualitative studies (Coutinho, Ribeiro, Hill, & Safran, 2011; Hill, Nutt-Williams, Heaton, Thompson, & Rhodes, 1996; Hill et al., 2003; Moltu, Binder, & Nielsen, 2010). Negative emotional reactions may tax the therapists' attention resources and thus, make it difficult to respond effectively (Kluger & DeNisi, 1996). Furthermore, the risk of losing face and damaging one's self-image prevent people from seeking negative feedback (Anseel, Beatty, Shen, Lievens, & Sackett, 2015), and also therapists have been shown to be prone to self-assessment bias (Walfish, McAlister, O'Donnell, & Lambert, 2012) and self-serving attributions (Murdock, Edwards, & Murdock, 2010). Such cognitive biases may make therapists less open to, and thus less likely to benefit from, negative feedback (Macdonald & Mellor-Clark, 2014).

A third barrier to learning from experience is that simply receiving and being open to negative feedback may not be enough to learn from it. Miller et al. (2015) suggested that the process of translating insight gained from feedback into actual behavior changes requires considerable effort. They recommended that therapists engage in "deliberate practice," that is, "setting aside time for reflecting on one's performance, receiving guidance on how to improve specific aspects of therapeutic practice, considering any feedback received, identifying errors, and developing, rehearsing, executing, and evaluating a plan for improvement" (Miller et al., 2015, p. 453; see also Tracey et al., 2014). In support of this model, Chow et al. (2015) found more effective therapists spent more time than less effective ones in solitary practice aimed at improving their skills.

Interacting with dissatisfied clients can clearly be challenging. The current study was designed to investigate how therapists experience, react to, and learn from negative, verbally expressed client feedback. Because of the explorative nature of the research questions, we adopted the qualitative methodology of Consensual Qualitative Research (CQR; Hill, 2012; Hill et al., 2005). Its main benefits are the integration of multiple perspectives to yield a more complex and less biased understanding of the data through rigorous and replicable analytic steps.

Method

Participants

Therapists. The participants were 18 therapists at a Norwegian mental health hospital. Demographic data was available for 16 of the therapists. The group consisted of 10 women and 6 men, with ages ranging from 28 to 64 years old ($M = 47.4$). Seven were clinical psychologists, six psychiatrists, and three other health care professionals. Highly experienced therapists dominated the sample. Five participants (31.3%) had worked as a therapist for more than 20 years, 10 (62.5%) for 10–20 years, and 1 (6.3%) for less than 5 years.

All 18 therapists provided information about theoretical orientation and attitudes toward clients' feedback. On a 4-point Likert scale (1 = low, 4 = high), they rated themselves as being strongly influenced by psychodynamic models ($M = 3.56$, $SD = 0.70$), followed by cognitive/behavioral models ($M = 2.67$, $SD = 0.78$) and humanistic/existential models ($M = 2.61$, $SD = 0.49$). Also on a 4-point Likert scale (1 = low, 4 = high), participants indicated that they felt confident as therapists ($M = 3.1$, $SD = 0.47$) and were highly ($M = 3.3$, $SD = 0.49$) concerned with their clients' perceptions of them and their way of working. Nine therapists (50%) reported receiving process feedback (i.e., meta-communications from clients about treatment) daily, 5 (27.8%) weekly, and the remaining 4 less frequently. Eight therapists did not use ROM in their work; the remaining had worked with the Partners for Change Outcome Management System (PCOMS; Bertolini & Miller, 2012; Duncan, 2012) for a period ranging from 2 months to 15 years. PCOMS utilizes regularly administered self-report questionnaires to track clients' progress in therapy as well as their experiences of the therapeutic alliance. As it is designed to facilitate communication of negative feedback and thus relates to the research questions, a comparison of therapists working with ROM versus those not doing so is presented in the results section.

Researchers. Following CQR guidelines (Hill, 2012), four researchers or judges conducted the investigation, and two auditors overlooked the process and gave feedback about the judges' conclusions throughout the process. Team members were selected to ensure a diversity of opinions and viewpoints. The principal investigator was a female, eclectically oriented clinical psychologist who at the time of the investigation worked on a doctoral thesis on ROM. The second judge was a female employee at a service user competence center, with experience being a therapy client and professional interest in examining psychotherapy processes from the client's point of view. The third judge was the male head of research department at the hospital mental health center where the investigation took place, and the fourth was a male, psychodynamically oriented clinical group psychologist. All judges had some prior experience conducting qualitative research. The auditors were a male professor in psychology and a female professor in psychiatry, both skilled in qualitative research methodology.

To increase awareness of factors that might influence the understanding of the data so that these might be set these aside or "bracketed" throughout the process, the team of judges reflected upon, discussed, and recorded their expectations (i.e., anticipated findings) and biases (i.e., personal issues that might make it difficult to respond objectively to the data) early in the investigation. A synthesis of the team's biases and expectations is presented here. All viewed client dissatisfaction as inevitable and highly important to acknowledge and work through in therapy. We expected negative feedback to elicit difficult feelings in the therapists that would make it challenging to think clearly and respond effectively, and speculated that they would be more likely to learn from the feedback if they attributed it to themselves rather than to the client. Although not mutually exclusive viewpoints, the first and second judges both tended to take client feedback at face value, with a bias toward understanding it as a result of some mistake made by the therapist, whereas the fourth judge leaned toward interpreting client dissatisfaction as transference or defense mechanisms and thus thinking that it reflected the client more than the therapist.

Questionnaire

The *Negative Client Feedback Questionnaire* was developed for this investigation in the following manner: First, the principal investigator conducted two face-to-face interviews with therapists to gain a preliminary understanding of the topic. Then, a pilot questionnaire was developed based on the interviews as well as our reading of relevant research literature and our own experiences as therapists and/or therapy clients. Finally, to test the questionnaire, it was administered to three therapists, and their answers as well as feedback from the external and internal auditors helped further refined the questions. Data from the pilot studies was not included in the analysis.

In the final questionnaire, therapists were asked to identify one specific episode when they had received negative feedback from a client. The experience was

then explored in detail through several open-ended questions following a structure similar to that used in several other CQR investigations (Coutinho et al., 2011; Rhodes, Hill, Thompson, & Elliott, 1994): (a) background of the event (i.e., "Describe briefly the clients' reasons for seeking therapy"), (b) description of the event and immediate context (i.e., "What was the feedback, and how was it communicated?"), (c) the participant's thoughts, feelings, and actions during the event (i.e., "What did you think in that moment? How did you feel?"), (d) how the event evolved (i.e., "How did the client react to your response ?"), (e) how the participant understands the event (i.e., "What are your thoughts about situation today?"), and (f) consequences of the event (i.e., "Has the experience had any consequences for you as a therapist and your work with new clients; if so, what?").

Procedures for Data Collection

Recruiting. Sixty therapists working at outpatient departments at a hospital mental health center in Mid-Norway were invited to participate. To promote participation, the principal investigator visited each of four teams in person and gave a presentation about the topic of negative client feedback. The invitation and information about the investigation was repeated in an e-mail that was sent to each of the 60 prospective participants immediately following the presentation. In total, 20 therapists (33%) returned the questionnaire. Two respondents did not describe a specific example and were excluded from the analysis, yielding a total of 18 cases in the final sample.

Administration. The questionnaire was administered via a web-based survey program (www.questback.com). E-mails with personal links to the survey were sent to each of the 60 invited therapists. These personal links were deleted following completion of the survey, and all demographic information (age, profession, and years of experience) was separated from the qualitative data by the administrator, so that no identifying information was contained in the raw data material that was made accessible to the research team. Consent to participation was given by completing the survey. The project was registered with the Norwegian Data Protection Authorities.

Working as a CQR Team

All judges had previously attended university-level courses in qualitative research. To familiarize ourselves with the methodology of CQR, we read and discussed Hill's (2012) book *Consensual qualitative research: A practical resource for investigating social science phenomena*, and made a plan for the analysis prior to conducting the investigation. Following CQR guidelines, in each step in the analysis, judges individually analyzed a previously agreed upon subset of cases or domains before working with the team to compare, discuss, adjust, and reach consensus. The process was then shortcut by splitting the team into pairs of judges, with the principal investigator serving on each pair, and sharing the remaining cases/domains between them. We counteracted power differences in the team by encouraging open expressions of differences of opinions and discussing differences in an accepting manner until the team reached consensus.

Data Analysis

The three major steps in a CQR data analysis are as follows: (a) segment raw data into domains, (b) formulate core ideas case for case, and (c) cross-analyze across all cases to identify similarities and formulate categories (see Hill, 2012).

Coding of domains and core ideas, and audit. Starting with a preliminary domains list based on the topics covered in the questionnaire, we sorted or coded the raw data (text from the questionnaire) into main thematic areas while continually modifying the domains list to fit the data. Core ideas (i.e., formulations of the content of interview data in clear and concise wording and incorporating relevant context; Hill, 2012) were then developed by carefully reading each case, parsing the interview data into smaller units according to content, and agreeing upon wording of the core idea. The resulting core ideas, with corresponding raw data and organized by domains case by case, were given to the auditors. Their feedback was discussed in the team, resulting in adjustments when deemed appropriate.

Cross-analysis, audit, and frequency calculations. Working with domain for domain and across all cases, core ideas that were similar in content were grouped together. Each of these groups or categories was given a label that reflected the content. Categories as well domains were repeatedly modified by frequently going back to the raw text to make sure that the categories represented the data, until a stable list of categories emerged. The list of domains and categories were audited and adjustments were made accordingly, resulting in a final three-level structure of the data: Domains consisting

of main categories consisting of sub-categories. Frequency labels were assigned to each of the categories according to how many cases it applied to. Following Hill's (2012) recommendation, categories were labeled *general* if present in all or all but one of the cases, *typical* if present in the range from half of the cases and up to the cutoff for the general, and *variant* if present less than half of the cases.

Development and comparison of subgroups. Following cross-analysis, we examined the category list with the research question ("When do therapists learn from negative feedback?") in mind. Two categories (titled "Repair" and "Meets new clients differently") were considered to be particularly relevant as they represented different manifestations or applications of learning. Accordingly, we sorted cases into two groups based on these categories, leaving remaining cases in a third group.

For each of the three groups of cases, categories were assigned frequency labels according to the same rules as those that guided the frequency calculations for the entire sample (i.e., the category was considered *general* if present in all or all but one of the cases within that group, *typical* if present in the range from half of the cases up to the cutoff for general within that group, and *variant* if present in less than half of the cases within that group; in addition, a category was given the frequency label *none* if not present in any cases within a given group). When comparing groups of cases, we followed the recommendations made by Hill (2012). Categories were considered more or less frequent in a given group if differing by two frequency categories from one or both of the other two groups (i.e., general vs. variant, typical vs. none). A comparison of cases described by ROM versus non-ROM users was done following the same procedure.

Results

The 18 texts that formed the basis for our analysis varied in length, ranging from 739 to 3172 words. We formulated 23–58 core ideas per case, resulting in 715 for the total sample. The results are presented in a three-level structure: Domains (thematic areas) consisting of main categories (sets of ideas with similar content) consisting of subcategories (descriptions of that content) (see Table I).

The structure of domains and categories as distributed across all cases is presented first, followed by in-depth description and comparison of the three different manifestations of learning that we identified in the body of cases, and finally a comparison of cases described by therapists working with ROM versus those not doing so.

Presentation of Domains and Categories

Domain I. Background. The main category "Client's presenting problems" refers to the therapists' description of the clients' reasons for seeking therapy. The subcategories "Relational difficulties," "Complex/comorbid psychopathology," and "Depression" were typical, whereas "Traumatized," "Anxiety" and "Personality disorders" were less frequent. Looking back at the "Therapeutic process prior to feedback," therapists typically indicated that there had been early "Indications of client dissatisfaction," but it was also typical that "Indications of client satisfaction." As a variant, "Therapist made attempts to resolve problems" before receiving the negative feedback.

Domain II. Negative feedback. As evident in the main category "Content of feedback," clients were typically "Dissatisfied with something specific," although "Global dissatisfaction" was also typical. Clients typically "Did not want to continue working with therapist," and a variant communicated that "Therapy did not help." The "Communication of feedback" was typically "Face to face" and variantly "With anger" and "In writing and/or through others." In none of the cases was the feedback obtained through ROM.

Domain III. Therapist reactions. The main category "Therapist covert reactions" refer to therapists' description of what went on inside them immediately after receiving the feedback. They typically "Experienced situation as challenging," "Experienced situation as unusual," had "Negative feelings toward client," and "Attributed dissatisfaction to client." Variant subcategories were "Negative feelings toward self," "Thought feedback was important," "Felt surprise," and "Self-critical thoughts." As for "Therapist actions," what therapists did when presented with the feedback, the typical response was to "Invite to further dialogue" (i.e., make room to discuss the feedback more thoroughly) and several subcategories occurred as variants: "Reflect after session," "Give in" (i.e., try to do as the client requested), "Flexibly accommodate," "Express understanding and support," "Explain" (including interpretation), "Apologize," and "Stay calm" (i.e., make efforts to regulate their own emotions).

Domain IV. Consequences of feedback. Typical in the main category "Consequence for

Table I. Therapists' reactions to negative feedback: domains and categories with frequency labels in total and within different manifestations of learning.

	Frequency			
		Within group		
Domain and category	Total	Immediately applied learning	Retrospectively applied learning	Non-applied learning
Domain I: Background				
Client's presenting problem				
Relational difficulties	Typical	General	General	Typical
Complex/comorbid psychopathology	Typical	General	*Variant*	General
Depression	Typical	Variant	Variant	*General*
Traumatized	Variant	Variant	Typical	Variant
Anxiety	Variant	Variant	Variant	Variant
Personality disorder	Variant	Typical	Variant	Variant
Therapeutic process prior to feedback				
Indications of client dissatisfaction	Typical	General	Typical	General
Indications of client satisfaction	Typical	General	General	*Variant*
Therapist made attempts to resolve problems	Variant	Variant	Variant	Variant
Domain II: Negative feedback				
Content of feedback				
Dissatisfied with something specific	Typical	General	General	*Variant*
Did not want to continue working with therapist	Typical	Variant	Typical	Typical
Global dissatisfaction	Typical	Variant	Variant	Typical
Therapy did not help	Variant	Variant	Variant	Variant
Communication of feedback				
Face to face	Typical	*General*	Typical	*Variant*
With anger	Variant	*General*	Variant	Variant
In writing and/or through others	Variant	Variant	Variant	Typical
Domain III: Therapist reactions				
Therapist covert reactions				
Experienced situation as challenging	Typical	*General*	Typical	*Variant*
Experienced situation as unusual	Typical	*Variant*	Typical	*General*
Negative feelings toward client	Typical	Typical	Variant	Variant
Attributed dissatisfaction to client	Typical	*General*	Variant	Variant
Negative feelings toward self	Variant	Typical	Typical	Variant
Thought feedback was important	Variant	*General*	Variant	Variant
Felt surprise	Variant	Typical	Variant	Variant
Self-critical thoughts	Variant	Variant	Variant	Variant
Therapist actions				
Invite to further dialogue	Typical	Typical	Variant	Typical
Reflect after session	Variant	Variant	Variant	Variant
Give in	Variant	Variant	Typical	Variant
Flexibly accommodate	Variant	*General*	*Variant*	*Variant*
Express understanding and support	Variant	Variant	Variant	Variant
Explain	Variant	Variant	Variant	Variant
Apologize	Variant	Variant	Variant	None
Stay calm	Variant	*Typical*	Variant	*None*
Domain IV: Consequences of feedback				
Consequence for client and therapy				
Client dissatisfaction persisted	Typical	Variant	Typical	Typical
Therapy discontinued	Variant	*None*	Variant	*Typical*
Client seemed relieved	Variant	*General*	Variant	Variant
Repair	Variant	*General*	Variant	*None*
Therapist understands event differently now	General	General	General	General
Self-acceptance and understanding	Typical	Typical	Typical	Typical
Understanding of own contribution to event	Typical	Variant	Typical	Typical
Understanding of relational aspects of event	Variant	Variant	Variant	Variant
Satisfaction with own management with situation	Variant	*General*	Variant	Variant
Understanding of the how client psychopathology influenced event	Variant	Variant	Variant	Variant

(*Continued*)

Table I. Continued.

Domain and category	Frequency			
		Within group		
	Total	Immediately applied learning	Retrospectively applied learning	Non-applied learning
Consequences for therapist				
Ideas about what to do differently	Typical	Variant	Typical	Typical
Changed feelings about self and therapy	Variant	Variant	Variant	Typical
Reminder of the importance of the client's perspective	Variant	Variant	Variant	Typical
Meets new clients differently	Variant	Variant	*General*	None

Notes. Within each category group, categories are listed in descending order according to frequency. Frequency labels: "General"—category present in all or all but one of the cases within the group; "typical"—category present in more than half of the cases within the group; "variant"—category present in from between two and half of the cases within the group. *Italics* indicate that a category is more/less frequent in a given group than in one or both other groups, differing by two frequency categories (i.e., general vs. variant, typical vs. none)

client and therapy" was that "Client dissatisfaction persisted" in the time following the feedback situation, while variant subcategories were "Therapy discontinued," "Client seemed relieved," and "Repair" (i.e., improved therapy process). The latter subcategory forms the base for the group Immediately Applied Learning and will be discussed in detail in the next section. A second main category, "Therapist understands the event differently now," refers to the new ideas that therapists generally expressed when discussing the situation in retrospect. They typically conveyed "Self-acceptance and understanding" of their own reactions and "Understanding of own contribution to event" (including mistakes they had made), and variantly "Understanding of relational aspects of event" (i.e., how the therapist's and the client's unique contributions interacted), "Satisfaction with own management of situation," and "Understanding of how client psychopathology influenced event." The "Consequences for therapist" were typically "Ideas about what to do differently" and variantly "Changed feelings about self and therapy" both in positive and negative direction, "Reminder of the importance of the client's perspective," and "Meets new clients diffently." The latter category forms the base of the group Retrospectively Applied Learning that is discussed in the next section.

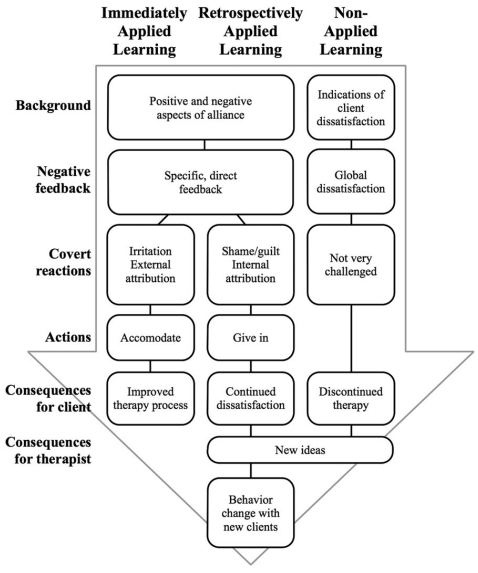

Figure 1. Summary of main findings.

Characteristics of Cases Describing Learning Manifested in Three Ways

Three manifestations of learning emerged from our analysis: Immediately Applied Learning (therapists changed their behavior in ways that improved the following process with the present client; occurred in six cases), Retrospectively Applied Learning (therapists described changes in his or her way of meeting new clients; occurred in eight cases) and Non-Applied Learning (therapists did not describe behavior changes that benefitted the present or future clients; occurred six cases). We understand these as different manifestations of learning that exist on a continuum rather than being mutually exclusive. In two cases, behavior changes that benefitted both the present and future clients were described. These were included in both the Immediately and Retrospectively Applied groups of cases. Characteristics of each manifestations of learning (i.e., categories that are general or typical within that group of cases

and/or more or less frequent in that group compared to the other two) are presented in the following (see also Figure 1).

Immediately applied learning. Cases were included when therapists described changes in their own behavior as a result of client's feedback that were maintained and helped improve the following therapy with that client (i.e., subcategory "Repair"). Their responses to the feedback incorporated a here-and-now, mutual learning—the client's feedback was processed in the dyad, and both the therapist and the client learned something that helped them relate differently to another in the future.

Background. Clients were generally described in terms of complex and comorbid psychopathology as well as relational difficulties. These were evident both in the therapy room and with others and included intimacy issues, feelings of inferiority, or difficulties adapting to social norms. Typical also was personality disorders. Much like with the other two manifestations of learning, therapists generally suspected that their clients were dissatisfied with treatment based on lack of progress, disagreement over goals or approach, or problematic client behavior such as withdrawing or acting aggressive, critical, or demanding. However, like therapists describing Retrospectively Applied Learning, they *also* generally highlighted indications that their clients were satisfied with treatment prior to the feedback, balancing positive and negative aspects (e.g., "He was skeptical, somewhat condescending in the first session […] I felt like he increasingly came to respect me, and that I challenged him just enough to raise interest and hope").

Negative feedback. The feedback generally concerned something specific that the therapist had or had not done. Examples include wanting medical treatment, not wanting to talk about specific topics that the therapist introduced, being outraged by something the therapist said, or not feeling understood. This was communicated face to face, typically with anger (e.g., "The client reacts strongly and becomes, as I see it, increasingly angry and upset").

Therapist reactions. The most frequent of the "Covert reactions" was feeling that the feedback was important (e.g., "I experienced the feedback as honest. She expressed something we'd both probably felt for some time") and challenging. Therapists were typically surprised by the feedback and reported negative emotions toward the client (e.g., "I was irritated with her "unreasonable" need for help, wish to be cared for despite her intellectual resources"). They typically also felt negatively toward themselves, but few had self-critical thoughts. Instead, they generally attributed the client's dissatisfaction to the client, often referring to transference or defense mechanisms (e.g., "Q: How did you understand the feedback? A: Passive aggression").

In terms of "Therapist actions," therapists generally accommodated client's request, often after some negotiation or trying out different strategies, for example, by accepting the client's request not to talk about certain topics, yet insisting that the client came back for another session before discontinuing therapy. They typically also described making conscious efforts to stay calm, for example, by "taking a step back" and reflect.

Consequences of feedback. The clients generally responded positively to the therapists' efforts to repair, for instance, accepting of the therapist's apology or displaying positive emotions (e.g., "The client seemed relieved, and the atmosphere in the room alleviated"). The relationship between therapist and client was described as improved as a result of the therapists' changed behavior (e.g., "Rather than being stuck in a closed system characterized by defense positions and anxiety, the client and I together managed to create the foundation of a new way of being together"). Many also reported that the client benefitted more from therapy in the following therapy.

Looking back, the therapists generally expressed satisfaction with how they had acted during the situation (e.g., "I think the boundaries that I tried to set for the client helped him in the long run, even though it was uncomfortable for me to encounter his reaction then and there"), and typically also conveyed acceptance and understanding of their own reactions. Only infrequently had the feedback had an influence on the therapists beyond the "here-and-now"-learning that led the therapists to change their behavior within that particular therapy.

Retrospectively applied learning. As indicated by the subcategory "Meets new clients differently," lessons learned through the feedback were manifested in therapists' behavior changes with future clients therapists in this group of cases.

Background. Clients were generally described as having relational difficulties and were typically traumatized (e.g., "Client is referred with a history of severe neglect and foster care placement where she suffered sexual abuse before puberty"). Generally, there were indications of client being satisfied with

the therapy prior to the feedback, although therapists also typically referred to early signs of client dissatisfaction.

Negative feedback. The content of the feedback was generally something specific the therapist had done or had failed to do, and these clients typically also said that they wanted to quit working with the therapist. This was typically communicated face to face (e.g., "The feedback was given directly, 'when you say things like that I can't talk to you anymore'"), but rarely in an agitated or angry fashion, in contrast to what was the case with Immediately Applied Learning.

Therapist reactions. No general categories emerged that described how therapists immediately felt inside when confronted with the negative feedback, although therapists typically experienced the situation as challenging and unusual and experienced negative feelings, such as shame or guilt, toward themselves (e.g., "I felt guilty about having, as he indicated, made him worse, felt completely helpless as all my attempts to talk about what happened between client and therapist 'stranded'"). Similarly, there were no general "Therapist actions." Therapists typically described giving in to the client's request and frequently going to some extent to try to fulfill the client's wishes, such as changing therapeutic style or behaving in ways that felt foreign to the therapist. Other strategies were sporadically referred to.

Consequences of feedback. The clients' dissatisfaction typically persisted, in most cases for an extended period of time, amounting to a continued struggle to improve the therapeutic relationship (e.g., "I think the client saw how I tried to change my therapeutic style, but that it did not quite work. Think she felt respected […] but that she still felt frustrated. She conveyed feeling that I cared for her, but that I was unable to give her what she needed."

In retrospect, therapists had typically gained a more nuanced and complex understanding of their own behavior, both *how* they had contributed to the client's dissatisfaction and the events that followed (e.g., "The feedback as I see it today probably referred to the treatment being a bit too 'superficial', and that I hadn't succeeded in touching upon emotions that were important to the client"), and *why* they reacted as they did (e.g., "I felt too warmly for the client. Perhaps got a little too eager to help").

In retrospect, the negative feedback had inspired various changes or adjustments in therapists' behavior toward new clients. The changes related to each therapist's understanding of why the client was dissatisfied in that specific instance; however, a common theme across all cases was attempting to bridge the gap between therapists' and clients' perspectives. For instance, behavior changes were aimed toward clarifying roles and responsibilities (e.g., "I now request more of the clients that I meet, therapy needs to be their (our) project, not something that I perform on someone"), changing routines to be able to be more present with clients (e.g., "I've gained more respect for [the importance of early alliance work] by making enough time and eliminating unnecessary stress before and after the first session with a client"), ascertaining that the therapist's interventions were well received (e.g., "I've become even more attentive toward making sure that my interpretations are palpable to the client and that it's understandable and acceptable for the client that I do what I do"), and meta-communicating more openly about the therapeutic relationship (e.g., "I've also become less afraid to explore what happens between me and the client so that it's hopefully easier to talk about the negative experiences in therapy").

Non-applied learning. Inspection of the cases where therapists did not describe any behavior changes following the feedback revealed that also in these cases, therapists described the feedback as influential and educational, most notably by generating new ideas.

Background. Clients were generally described as being depressed in addition to having complex psychopathologies and typically also relational difficulties. Therapists generally reported that there were early indications of client dissatisfaction. In contrast to the two applied learning case groups however, few therapists reported any indications of their clients also being satisfied prior to the feedback situation.

Negative feedback. Clients typically expressed a global dissatisfaction with the therapist, often referred to as "bad chemistry" or general, nonspecific dislike of the therapist. Most clients communicated that they wanted to quit working with the therapist (e.g., "She ended the contact, said that 'this does not suit me'"). The negative feedback was typically communicated indirectly, in letters, e-mails, or through others such as the client's family members or the client's physician.

Therapist reactions. The situation was generally experienced as unusual to the therapist (e.g., "I haven't had similar experiences with other clients

that I can think of"), but few experienced it as challenging, and they rarely reported negative feelings. Their most typical reaction was to invite to further dialogue (e.g., "I offered to continue our contact and suggested that we talk about the things that didn't work between us in order to set a new course together"). Few had made efforts to accommodate the client, and none apologized.

Consequences of feedback. The client's dissatisfaction typically persisted, and most clients terminated therapy shortly after the feedback situation (e.g., "The client quit and I haven't seen her since"). Like in Retrospectively Applied Learning, therapists typically reported a change in how they understood their own contribution to the situation from the time it occurred to the present, both in terms of how their own actions influenced the event, and in acceptance and understanding of how they had reacted. They typically reported that the feedback changed how they felt about themselves and their work (e.g., "I think my professional self-esteem suffered a blow"). The feedback had typically given them a reminder of the importance of the client's perspective (e.g., "I think it illustrates the importance of getting the client's reactions to me as therapists, and any differences in theory of change, "on the table," talk about it") and new ideas about what to do differently if they were to find themselves in a similar situation in the future (e.g., "I would focus more on where the client is at. Not assume that the client intuitively see that it's wise to let one's wishes, dreams and needs guide one in life"). In contrast to with the other two groups of cases, however, this new insight was not described as having translated into changed behavior with new clients.

Comparison of Cases Reported by Therapists Using Versus Not Using ROM

To examine if working with ROM influenced how therapists understood and responded to the negative feedback, we compared the 10 cases reported by ROM users to the eight cases reported by therapists who did not work with ROM. Two therapists made references to feedback obtained through PCOMS (Bertolini & Miller, 2012; Duncan, 2012) in their descriptions of the background to the feedback (e.g., "The feedback on PCOMS was […] within the 'green area'"). In none of the cases did ROM feature in the description of the actual feedback event, nor in the consequences of the event. Cases described by ROM vs. non-ROM users were found to differ only in the subcategory "Indications of client satisfaction," with therapists working with ROM generally and those not working with ROM only variantly mentioning signs of clients being satisfied with treatment prior to the feedback. The category "Indications of client dissatisfaction" was typical within both categories. ROM users generally reported cases that were classified as Immediately Applied Learning, typically cases that were classified as Retrospectively Applied Learning, and variantly cases that were classified as Non-Applied Learning.

Discussion

The 18 therapists' narratives provide rich descriptions of their reactions to negative feedback from clients. All described the feedback as educational, but learning was manifested in different ways. In the cases we categorized as Immediately Applied Learning, therapists used the insight that the feedback gave them to adjust their own behavior with that client, leading to improved therapy processes and outcomes. In Retrospectively Applied Learning cases, the feedback inspired changes in therapists' way of working with new clients, specifically behaviors aimed toward bridging the gap between clients' and therapists' diverging perspectives. Finally, in the Non-Applied Learning cases, new insight and ideas that had been generated by the feedback had not led therapists to change their behavior. When comparing cases describing these manifestations of learning, we found consistent differences both the nature of the feedback and the therapists' reactions to it.

The Nature of the Feedback

Our results support feedback theory (Sapyta et al., 2005) in emphasizing the value of direct, specific, and promptly delivered feedback. Therapists who had been given face-to-face, unambiguous feedback about something they had done or failed to do were more often able to use this new information in ways that benefitted the current and/or future clients. This contrasted with the global, nonspecific, and indirectly communicated dissatisfaction that was described in the Non-Applied Learning cases. Therapists' experiences in these latter cases bear similarities to those of therapists in a qualitative study of the impact of premature termination (Piselli, Halgin, & MacEwan, 2011): Several general and vague ideas about what they could have done differently, yet a global sense of insecurity about how to prevent similar situations from happening again due to the lack of unambiguous, specific information about what went wrong.

The quality of the therapeutic relationship may help explain why the clients' feedback was specific and direct in some cases and not in others. In accordance with the finding that therapists tend to view the therapeutic alliance in slightly less positive terms than clients do (Tryon, Blackwell, & Hammel, 2007), most participants in our study mentioned problematic aspects of the therapeutic alliance prior to the feedback. However, in the cases where therapists had applied what they had learned with clients, they also mentioned indications of client satisfaction. The overall description of the early alliance was thus more nuanced and more positive in Immediately and Retrospectively Applied Learning than in Non-Applied Learning, where the feedback was non-specific and indirectly communicated. Consistent with this, qualitative investigations of clients' experiences of misunderstandings in therapy (Rhodes et al., 1994) and premature termination (Knox et al., 2011) found that poorer therapeutic relationships made it more difficult for clients to talk to their therapists about their dissatisfaction.

Only in the Immediately Applied Learning cases did the therapists generally perceive the clients as agitated or angry during the feedback situation. We speculate that the clients' anger may have helped convey to the therapists the importance of the feedback and motivated their efforts to resolve the situation, as these cases are characterized by therapists immediately feeling that the feedback was important and trying out a variety of repair strategies with the client, in contrast to the other two expressions of learning

The Therapists' Reactions

In Immediately Applied Learning cases, therapists understood the client's dissatisfaction as a result of his or her pathology. This is in accordance with the central idea in dynamic theory that the client's interpersonal problems are acted out in the therapeutic relationship and pose a challenge to alliance formation but also possibilities for therapeutic change (Hill & Knox, 2009; Horvath & Bedi, 2002). Other lines of research however give reason to caution against therapists' blaming the client rather than assuming responsibility when therapy fails. Sapyta et al. (2005) suggested that therapists are less likely to change ineffective behavior when they use external attribution as a way of reducing the cognitive dissonance that results from negative feedback, and Murdock et al. (2010) demonstrated that therapists' external attribution of premature termination had elements of self-image preserving biases. Others (Henry, Schacht, & Strupp, 1990; von der Lippe, Monsen, Ronnestad, & Eilertsen, 2008) have documented increasingly more problematic interactions and poor therapy outcomes when therapists respond to client hostility with hostility of their own. Nissen-Lie and colleagues found that therapists who more often experienced professional self-doubt had better outcomes with clients (Nissen-Lie, Monsen, Ulleberg, & Ronnestad, 2013) and formed better alliances (Nissen-Lie, Monsen, & Ronnestad, 2010), and Chow et al. (2015) reported that the most effective therapists were more often surprised by their clients' feedback, which the authors interpreted as indicative of an open attitude toward feedback. Finally, de Jong, van Sluis, Nugter, Heiser, and Spinhoven (2012) found that clients of therapists with an "internal feedback propensity" (preference for relying upon their own judgments rather than feedback from others) had slower rates of change, although "external feedback propensity' did not moderate the effect of feedback on outcome in this study.

Contrary to our expectations given these research findings, even while engaging in external attribution and having negative emotional reactions therapists in Immediately Applied Learning responded in ways that contributed *positively* to the therapeutic relationship. What they described doing was similar to the process of repairing alliance ruptures (i.e., tensions or breakdowns in the collaboration between therapist and client) described by Safran and Muran (2000): Inviting the client to examine the feedback together and repairing the rupture through flexible negotiation and accommodation, without neither loosing nor stubbornly defending their own stance. Our analysis did not yield a clear explanation of how they managed to do this; however, it is possible that external attribution may have been less personally challenging, and the accompanying other-directed negative emotions easier to regulate, than the guilt and shame that dominated in Retrospectively Applied Learning. Thus, external attribution may have actually helped therapists remain open enough to the feedback to make it possible to respond effectively to it in these cases. In support of this, therapists typically reported being surprised by the feedback and immediately thinking that it was important, indicating perhaps the openness to feedback without being derailed by it that has been described as one of the characteristics of master therapists (Jennings & Skovholt, 1999).

In cases where Retrospectively Applied Learning was described, a different pattern of reactions dominated. Therapists reported immediately feeling shame, guilt, or other negative emotions directed toward themselves. Perhaps motivated by this,

their most frequent behavioral response was doing exactly as the client requested, for instance, by trying to change their therapeutic style. The therapists' giving in may have prevented many of these clients from terminating therapy. Nevertheless, problematic aspects of the strategy are suggested by the typical persistence of the clients' dissatisfaction following the feedback in these cases. We note similarities between what these therapists did, and what Nissen-Lie et al. (2015) conceptualized as non-constructive coping mechanisms (among other behaviors, acting out by postponing the work of therapy or making changes to the therapeutic contract) and found to be associated with less client change.

Looking back, very few therapists in the Retrospectively Applied Learning cases were satisfied with how they managed the situation. Lingering self-negative feelings may have increased their motivation to change something in their way of working to prevent similar situations from happening. What they experienced was perhaps one in the "series of humiliations" that therapists in Ronnestad and Skovholt's (2012) large-scale investigation of therapist development went through when confronted with their own fallibility. Another finding from this study is the importance of continuous reflection as a prerequisite for learning; similarly, in our investigation, therapists had arrived at a more nuanced understanding of their own contributions to the situation in retrospect, suggesting that they had spent some time reflecting on what had happened. The behavior change that followed might have been informed by the specific negative feedback they had received as suggested in the feedback model by Sapyta et al. (2005). Presumably, the changes they had made in their way of meeting new clients helped them form better alliances with new clients, although the design of this study does not provide any actual outcome data.

It is interesting to note that while almost all therapists in our investigation cited psychodynamic theory as their most important influence in their work, only in the cases describing Immediately Applied Learning did they seem to apply the model to the situation: Conceptualizing the feedback as revealing something of the client's dynamic, and providing corrective emotional experiences and insight for the clients through exploration of the situation and repair of the impasse. As discussed above, we suggest that emotion regulation differentiated this group from the other two. Emotion regulation is central in the psychodynamic concept of countertransference management, and consistent with our findings, successful managing of countertransference has been found to be associated with better therapy outcomes (Hayes, Gelso, & Hummel, 2011). While it is unclear why some therapists were able to handle their emotions or countertransference reactions better than others, one possibility is in the nature of the feedback: In Immediately Applied Learning, clients expressed their dissatisfaction with anger, which may have triggered irritation rather than guilt or shame in their therapists. In contrast, clients in the Retrospectively Applied Learning cases typically wanted to discontinue working with the therapist, which may have indicated a more severe message from the client that the therapist was at fault. Therapist and/or client factors may also help explain the difference between groups. This will be discussed in the next section.

The Clients' and Therapists' Contributions

In this investigation, we have consciously chosen not to include the information that the therapists gave about themselves in the analysis (with the exception of use of ROM, see below). The reason for this is the problems of representativeness and generalizability that are inherent in our design, with each therapist describing just one negative feedback event that may or may not have been typical for that particular therapist. Similarly, we hesitate to speculate about whether or not characteristics of the clients explain our results, as the descriptions of the clients' behavior and psychopathology are filtered through the therapists' retrospective narrative, with no information from the clients themselves or other parties. Nevertheless, our results raise some interesting questions about what each of the two parties brought into the interaction. As discussed in Schröder, Orlinsky, Rønnestad, and Willutzki's (2015) summary of various lines of research on therapist difficulties, there are at least two sides to any story of negative therapy processes: The therapist's personality and ability to deal with problems as well as the client's interpersonal style and problems.

With regards to the therapists' contribution, we found that most of the ROM users described cases where the feedback had led to either Immediately or Retrospectively Applied Learning; therapists not working with ROM dominated the cases that were categorized as Non-Applied Learning. This raises the possibility that ROM users elicit, understand, and/or respond to negative feedback differently. Our study was however not designed to explore this issue and does not provide unambiguous information regarding how ROM influences therapists' attitudes toward client feedback. In comparison of the cases described by ROM vs. non-ROM users, only the subcategory of the quality of the relationship prior to the

feedback event differed between the two groups, with ROM-users generally and non-ROM users only variantly mentioning indications of a positive alliance. ROM never featured in the descriptions of the feedback events nor its consequences, although mentioned by a few therapists when discussing the background to the events. One possible interpretation is that the feedback obtained through ROM is of a different character, perhaps more tied to specific aspects of the therapy process and thus, less salient and memorable, than the events that therapists chose to describe when responding to this investigation.

Our knowledge of client characteristics that may have influenced the events described is limited to the therapists' (possibly biased) descriptions of their clients' psychopathology. In Immediately Applied Learning cases, clients were generally described as having relational difficulties and personality disorders, and the therapists responded in accordance with the dynamic model by attributing the feedback to the client and handling it by flexible negotiation. In the Retrospectively Applied Learning cases, clients were typically described as traumatized. We speculate that therapists' compassion and empathy, when faced with victims of trauma, may have made them more likely to turn frustration with the negative feedback toward themselves, and to give in to clients' requests. Finally, in the Non-Applied Learning cases, clients were generally depressed, raising the possibility that their choices no to give direct feedback and drop out of treatment may have been caused by the hopelessness and lack of initiative that is symptomatic of depression.

Limitations

The study design, with therapist reported, written, retrospective accounts, limits the conclusions that can be drawn from this study. The descriptions of the negative feedback situations were filtered through the therapists' perceptions, without any client data to fill in gaps or correct possible misrepresentations of the clients or the situations. What the participants remembered and chose to describe may have been influenced by their wish to share a certain narrative and their knowledge of the events that followed, and other, potentially valuable information was possibly under-communicated or lost. For instance, the description of the pre-feedback relationship as more problematic in the Non-Applied Learning group than in the other two groups may be the result the therapists' cognitive and affective processes such as motivation to explain why therapy had failed. Possibly, the written format of our investigation accentuated memory biases, as the absence of an interviewer that challenges the participant's history or asks in-depth explorative questions might make it less likely for new and unexpected information to come to light (Kvale & Brinkmann, 2009). On the other hand, the written format may have made social face-serving concerns less influential and thus facilitated sharing of personally difficult material.

More cases and richer descriptions of each case would have increased confidence our in the results. Two of the groups contain six cases each, one short of Hill's (2012) recommendations for subsample size when comparing groups. Furthermore, each participant described just one instance of negative feedback of their own choosing. Presumably these events were selected because they stood out in some way to the therapists, and we do not assume that they are representative for each particular therapist and also not for therapists in general. Rather, we understand them as different expressions of learning processes that therapists may experience with different clients or even within the same therapy. Our aim was to explore and work toward understanding an area where there is little prior knowledge.

Finally, the researchers' expectations and biases may have influenced our findings. We did, however, take some precautions in selecting a research team that represented different background and perspectives, record and continually refer back to our biases and expectations, and critically question our own interpretations during the analysis. The effect of bracketing biases and expectations is illustrated by the unexpectedness of some of our findings, such as three different manifestations of learning and the external attribution in the Immediately Applied Learning cases.

Implications for Practice

While the qualitative design limits the ability to generalize from our results, therapists may find aspects of them transferrable to their own practices. Our results highlight the importance of obtaining clear, unambiguous feedback about the clients' negative reactions to therapy. Therapists should be aware that clients may hesitate to express dissatisfaction, and work toward creating a safe therapeutic environment where meta-communicating about the therapeutic relationship is possible. One of the ROM systems that are available may be found to be of help, for instance, one that includes alliance feedback such as the PCOMS (Bertolini & Miller, 2012; Duncan, 2012) or the OQ system (Lambert, 2004).

We found that negative feedback elicited difficult feelings that even these experienced therapists had difficulties coping with. Therapists would be well

advised to pay attention to their own emotional reactions, and regulate rather than act out difficult feelings when they arise. It may be especially challenging to cope constructively with self-directed negative feelings. We would suggest that openness around this seemingly normal phenomenon would be helpful to reduce shame and guilt, perhaps especially for new therapists.

Furthermore, when therapists experience difficult therapy processes or premature termination, it might be constructive for their own professional development to consider what their own contributions to the interaction may have been, think about what they could have done differently, and try this out with new clients. Based on our results, we would suggest that programs aimed at training novice therapists focus both on how to obtain, receive, and respond to negative feedback, and how to use information from clients to improve one's skills.

Implications for Research

We believe that this investigation provides a good first step toward understanding how therapists react to negative feedback. It also raises some interesting questions that could be investigated further, such as: How do therapists translate new insights into new skill sets? When do therapists maintain and when do they lose the balance between being open to and assuming responsibility for negative feedback on the one hand, and having an understanding of the client's contribution to negative processes on the other hand? How much of negative processes can be attributed to different sources such as the client, the therapist, and the unique interaction between the two? It would be interesting to see some of these questions investigated with different research methodologies. Associating therapists' experiences with client outcome data would be of particular interest, as it is unclear whether or not the therapists' experiences of repairing and learning in our study translated into actual client benefits. The clients' perspectives on giving feedback to therapists should not be neglected. Finally, we suggest that incorporating situational and contextual factors in the study of therapist variability may shed further light on when therapists work efficiently and when not.

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References

Anseel, F., Beatty, A. S., Shen, W., Lievens, F., & Sackett, P. R. (2015). How are we doing after 30 years? A meta-analytic review of the antecedents and outcomes of feedback-seeking behavior. *Journal of Management*, *41*(1), 318–348.

Bertolini, B., & Miller, S. D. (2012). *ICCE manuals on feedback-informed treatment* (Vols 1–6). Chicago, IL: ICCE Press.

Beutler, L., Malik, M., Alimohamed, S., Harwood, T., Talebi, H., & Noble, S. (2004). Therapist variables. In M. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 226–306). New York, NY: John Wiley & Sons.

Binder, J. L., & Strupp, H. H. (1997). "Negative process": A recurrently discovered and underestimated facet of therapeutic process and outcome in the individual psychotherapy of adults. *Clinical Psychology: Science and Practice*, *4*(2), 121–139.

Blanchard, M., & Farber, B. A. (2015). Lying in psychotherapy: Why and what clients don't tell their therapist about therapy and their relationship. *Counselling Psychology Quarterly*, *29*(1), 90–112.

Chow, D. L., Miller, S. D., Seidel, J. A., Kane, R. T., Thornton, J. A., & Andrews, W. P. (2015). The role of deliberate practice in the development of highly effective psychotherapists. *Psychotherapy*, *52*(3), 337–345.

Claiborn, C. D., & Goodyear, R. K. (2005). Feedback in psychotherapy. *Journal of Clinical Psychology*, *61*(2), 209–217.

Coutinho, J., Ribeiro, E., Hill, C., & Safran, J. (2011). Therapists' and clients' experiences of alliance ruptures: A qualitative study. *Psychotherapy Research*, *21*(5), 525–540.

Duncan, B. L. (2012). The partners for change outcome management system (PCOMS): The heart and soul of change project. *Canadian Psychology/Psychologie Canadienne*, *53*(2), 93–104.

Farber, B. A. (2003). Patient self-disclosure: A review of the research. *Journal of Clinical Psychology*, *59*(5), 589–600.

Goldberg, S. B., Rousmaniere, T., Miller, S. D., Whipple, J., Nielsen, S. L., Hoyt, W. T., … Wampold, B. E. (2016). Do psychotherapists improve with time and experience? A longitudinal analysis of outcomes in a clinical setting. *Journal of Counseling Psychology*, *63*(1), 1–11.

Hayes, J. A., Gelso, C. J., & Hummel, A. M. (2011). Managing countertransference. *Psychotherapy*, *48*(1), 88–97.

Henry, W. P., Schacht, T. E., & Strupp, H. H. (1990). Patient and therapist introject, interpersonal process, and differential psychotherapy outcome. *Journal of Consulting and Clinical Psychology*, *56*(8), 768–774.

Hill, C. E. (2012). *Consensual qualitative research: A practical resource for investigating social science phenomena*. Washington, DC: American Psychological Association.

Hill, C. E., Kellems, I. S., Kolchakian, M. R., Wonnell, T. L., Davis, T. L., & Nakayama, E. Y. (2003). The therapist experience of being the target of hostile versus suspected-unasserted client anger: Factors associated with resolution. *Psychotherapy Research*, *13*(4), 475–491.

Hill, C. E., & Knox, S. (2009). Processing the therapeutic relationship. *Psychotherapy Research*, *19*(1), 13–29. doi:10.1080/10503300802621206

Hill, C. E., Knox, S., Thompson, B. J., Williams, E. N., Hess, S. A., & Ladany, N. (2005). Consensual qualitative research: An update. *Journal of Counseling Psychology*, *52*(2), 196–205.

Hill, C. E., Nutt-Williams, E., Heaton, K. J., Thompson, B. J., & Rhodes, R. H. (1996). Therapist retrospective recall of impasses in long-term psychotherapy: A qualitative analysis. *Journal of Counseling Psychology*, *43*(2), 207–217.

Hill, C. E., Thompson, B., & Corbett, M. (1992). The impact of therapist ability to perceive displayed and hidden client reactions on immediate outcome in first sessions of brief therapy. *Psychotherapy Research*, *2*(2), 143–155.

Hill, C. E., Thompson, B. J., Cogar, M. C., & Denman, D. W. (1993). Beneath the surface of long-term therapy: Therapist and client report of their own and each other's covert processes. *Journal of Counseling Psychology*, *40*(3), 278–287.

Horvath, A., & Bedi, R. (2002). The alliance. In C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 37–69). London: Oxford University Press.

Howard, K. I., Moras, K., Brill, P. L., Martinovich, Z., & Lutz, W. (1996). Evaluation of psychotherapy: Efficacy, effectiveness, and patient progress. *American Psychologist*, *51*(10), 1059–1064.

Jennings, L., & Skovholt, T. M. (1999). The cognitive, emotional, and relational characteristics of master therapists. *Journal of Counseling Psychology*, *46*(1), 3–11.

de Jong, K., van Sluis, P., Nugter, M. A., Heiser, W. J., & Spinhoven, P. (2012). Understanding the differential impact of outcome monitoring: Therapist variables that moderate feedback effects in a randomized clinical trial. *Psychotherapy Research*, *22*(4), 464–474.

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.

Knox, S., Adrians, N., Everson, E., Hess, S., Hill, C., & Crook-Lyon, R. (2011). Clients' perspectives on therapy termination. *Psychotherapy Research*, *21*(2), 154–167. doi:10.1080/10503307.2010.534509

Kvale, S., & Brinkmann, S. (2009). *Interviews: Learning the craft of qualitative research interviewing*. London: Sage.

Lambert, M. J. (2004). *Administration and scoring manual for the OQ-45.2 (outcome questionnaire)*. Salt Lake City, UT: OQ Measures, LLC.

Lambert, M. J. (2007). Presidential address: What we have learned from a decade of research aimed at improving psychotherapy outcome in routine care. *Psychotherapy Research*, *17*(1), 1–14.

Macdonald, J., & Mellor-Clark, J. (2014). Correcting psychotherapists' blindsidedness: Formal feedback as a means of overcoming the natural limitations of therapists. *Clinical Psychology & Psychotherapy*, *22*(3), 249–257.

Miller, S. D., Hubble, M. A., Chow, D., & Seidel, J. (2015). Beyond measures and monitoring: Realizing the potential of feedback-informed treatment. *Psychotherapy*, *52*(4), 449–457.

Moltu, C., Binder, P.-E., & Nielsen, G. H. (2010). Commitment under pressure: Experienced therapists' inner work during difficult therapeutic impasses. *Psychotherapy Research*, *20*(3), 309–320.

Murdock, N. L., Edwards, C., & Murdock, T. B. (2010). Therapists' attributions for client premature termination: Are they self-serving? *Psychotherapy: Theory, Research, Practice, Training*, *47*(2), 221–234.

Nissen-Lie, H. A., Monsen, J. T., & Ronnestad, M. H. (2010). Therapist predictors of early patient-rated working alliance: A multilevel approach. *Psychotherapy Research*, *20*(6), 627–646.

Nissen-Lie, H. A., Monsen, J. T., Ulleberg, P., & Ronnestad, M. H. (2013). Psychotherapists' self-reports of their interpersonal functioning and difficulties in practice as predictors of patient outcome. *Psychotherapy Research*, *23*(1), 86–104.

Nissen-Lie, H. A., Rønnestad, M. H., Høglend, P. A., Havik, O. E., Solbakken, O. A., Stiles, T. C., & Monsen, J. T. (2015). Love yourself as a person, doubt yourself as a therapist? *Clinical Psychology & Psychotherapy*. Advance online publication. doi:10.1002/cpp.1977

Piselli, A., Halgin, R. P., & MacEwan, G. H. (2011). What went wrong? Therapists' reflections on their role in premature termination. *Psychotherapy Research*, *21*(4), 400–415.

Regan, A. M., & Hill, C. E. (1992). Investigation of what clients and counselors do not say in brief therapy. *Journal of Counseling Psychology*, *39*(2), 168–174.

Rhodes, R. H., Hill, C. E., Thompson, B. J., & Elliott, R. (1994). Client retrospective recall of resolved and unresolved misunderstanding events. *Journal of Counseling Psychology*, *41*(4), 473–483.

Ronnestad, M. H., & Skovholt, T. M. (2003). The journey of the counselor and therapist: Research findings and perspectives on professional development. *Journal of Career Development*, *30*(1), 5–44.

Ronnestad, M. H., & Skovholt, T. M. (2012). *The developing practitioner: Growth and stagnation of therapists and counselors*. New York, NY: Routledge.

Safran, J. D., & Muran, J. C. (2000). *Negotiating the therapeutic alliance: A relational treatment guide*. New York, NY: Guilford Press.

Sapyta, J., Riemer, M., & Bickman, L. (2005). Feedback to clinicians: Theory, research, and practice. *Journal of Clinical Psychology*, *61*(2), 145–153.

Schröder, T., Orlinsky, D., Rønnestad, M. H., & Willutzki, U. (2015). Psychotherapeutic process from the psychotherapist's perspective. In O. C. G. Gelo (Eds.), *Psychotherapy research* (pp. 351–365). Wien: Springer-Verlag.

Tracey, T. J., Wampold, B. E., Lichtenberg, J. W., & Goodyear, R. K. (2014). Expertise in psychotherapy: An elusive goal? *American Psychologist*, *69*(3), 218–229.

Tryon, G. S., Blackwell, S. C., & Hammel, E. F. (2007). A meta-analytic examination of client–therapist perspectives of the working alliance. *Psychotherapy Research*, *17*(6), 629–642.

von der Lippe, A. L., Monsen, J. T., Ronnestad, M. H., & Eiertsen, D. E. (2008). Treatment failure in psychotherapy: The pull of hostility. *Psychotherapy Research*, *18*(4), 420–432.

Walfish, 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.