Measuring Outcome of Feedback-Informed Treatment:

Using PCOMS with Chinese Clients

(Capstone Project)

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Chapter One

Introduction

Miller, Hubble & Duncan (1995) stated that the number of therapy models has increased, mushrooming from 60 to more than 400 since the mid-1960s; decades of clinical outcome research has not found anyone theory, model, method, or package of techniques to be reliably better than any other. Virtually all of the available data indicates that the different therapy models, from psychodynamic and client-centered approaches to marriage and family therapies, work equally well. What makes psychotherapy work? It perplexed generations of psychotherapists. Tracing back to 1963 and 1964, the initial debate about the potency of psychotherapy between Eysenck and Strup made lingering ripples in the mental health field. Numerous studies have demonstrated the efficacy and effectiveness of a variety of psychotherapeutic approaches (Lambert & Ogles, 2004).

Miller, Hubble & Duncan's research evidence clarifies that the similarities rather than the differences between models account for most of the change that clients experience across therapies. What emerges from examining these similarities is a group of common factors that cut across models and contrast sharply with the current emphasis on differences in theory and technique characterizing most professional discussion. Four common factors, each central to all forms of therapy despite theoretical orientation, mode, or dosage (frequency and number of sessions), underlie the effectiveness of therapy. (1) *Therapeutic Technique.* In his widely cited review of psychotherapy outcome research, Lambert (2003, 2010) estimated that the therapist's model and technique contribute only 15% of the impact of psychotherapy. (2) *Expectancy and Placebo.* As a factor in the outcome, technique matters no more than the "placebo effect." The increased hope and positive expectation for change that clients experience simply from making their way into treatment. (3) *Therapeutic Alliance.* Studies show that the consumer's participation in therapy is

the single most important determinant of outcome (Anker, M. Owen, J., Duncan, B. L., & Sparks, J. A., 2010). Lambert (2003,2010) estimated that the therapeutic relationship contributes a hefty 30% to psychotherapy. Clients who are motivated, engaged, and connected with the therapist in a joint endeavor will benefit the most from therapy. (4) *Client Factors.* The client is the single most potent factor, contributing an impressive 40% to the outcome. Over the last four decades, there has been consistent evidence for the contribution of common factors in promoting therapeutic change across various psychotherapy models (Asay & Lambert, 2006; Duncan, 2010).

Therapeutic Alliance and Client factors account for the most in therapy outcome. Therefore, a system to measure the therapist-client relationship and psychotherapy progress is key to treatment outcomes (Lambert & Barley, 2001). Recent studies have shown that feedback affects clinician-rated measures and outcomes. Also, the measurement and management of change have become an essential topic in delivering mental health services (Duncan, Miller, & Sparks et al., 2003). Monitoring treatment outcome, a process often called "client feedback," has become a recommended evidence-based practice for therapists (Duncan, 2012; Lambert, 2010). Client feedback typically involves a client completing a self-report measure of general distress before each psychotherapy session to monitor treatment progress (Toland, Li, Kodet, & Reese, 2020). Based on Lambert et al. (2003) and Miller, Duncan et al. (2006) studies, monitoring client-based outcome, when combined with feedback to the clinician, increases the effectiveness of clinical services by an impressive 65% in real clinical settings (Sparks et al., 2006). Furthermore, the need for tracking client progress is reinforced by data indicating that therapists need independent data to alert them when treatment is not having its intended effects (Hannan et al., 2005; Slade, Lambert et al.,2008). Therefore, to reduce adverse outcomes, routine outcome monitoring (ROM) has been proposed.

Monitoring outcomes routinely, some measures have been invented, and there are two outstanding systems. These two client feedback systems have been the most widely studied about their impact on an individual client's psychotherapy outcome. Lambert et al. (2018) and his colleagues invented the Outcome Questionnaire System (OQ- 45). In response to a need for a feasible and brief means for obtaining client feedback and evaluating treatment outcomes, Miller and Duncan (2000,2008) developed the Partners for Change Outcome Management System (PCOMS). Both PCOMS and OQ-45 have been listed in the Substance Abuse and Mental Health Administration's National Registry of Evidence-based Programs and Practices (Lambert et al., 2018). Also, OQ-45 and PCOMS have been empirically supported in a better outcome with individuals, but only PCOMS has demonstrated significant improvement in couples and families (Spark, Duncan, 2018).

PCOMS is theorized to be useful for two reasons. First, getting feedback from clients directly and engaging clients in an ongoing process of measuring and discussing both progress and the alliance (Miller, Duncan et al., 2003; Mikeal et al., 2016). Second, PCOMS includes a real-time comparison to normative data that consists of expected treatment response to gauge progress and signal when change is not occurring as predicted (Duncan, 2012). With this alert, clinicians and patients have an opportunity to shift focus, revisit goals, or alter interventions before a negative outcome ensues (Reese, Duncan et al., 2018).

I choose this research topic because I work on my internship site, adopting feedback-informed treatment and PCOMS measures for years. I was initially fascinated by how easy and straightforward to implement this client feedback/outcome measure. Then I wondered that if this measure works equally effectively with different ethnicities. Firstly, I worked out my research keyword list, synonyms, and keywords mix and match. The keyword list includes client feedback,

routine outcome measures, feedback informed treatment, PCOMS technology, the effectiveness of PCOMS, the effectiveness of client feedbacks, deliberate practice, evidence-based practice, treatment failure, Asian clients, Chinese client outcome, deterioration rate, and dropout rate in therapy, etc. Second, to make sure that I can get a good variety of resources and an idea of what information was available to me, I started my general research in Google Scholar. Then, I selected Taylor and Francis, and ProQuest as my databases to start advanced research and requested 120 articles through interlibrary loans at the City University of Seattle. Some of these articles were theoretical articles that discussed the effectiveness of therapy generally, the common factors that contribute to client change, or the meta-analysis of evaluating outcomes. Some items analyzed outcomes at the therapist level. Some articles described and evaluated specific outcome assessments. I worked with many Chinese clients during my practice, and I am interested in knowing how PCOMS would do differently on different people groups. Therefore, I narrowed my research on existing RCTs and meta-analysis when using a client feedback system on Asian and Chinese clients.

Context of the Problem

Concerns about dropout rates were compounded by indications that therapists had difficulty detecting clients at-risk for treatment failure (Hannan et al., 2005). However, Boswell Kraus, Miller & Lambert (2015) pointed out that one core element of feedback systems is their proven ability to predict treatment failure, risk of hospitalization, or other negative outcomes. Improving outcomes of clients who respond poorly to treatment, such clients must be identified before termination, and ideally as early as possible in the course of treatment. As such, a feedback system, PCOMS has been empirically approved to predict treatment failure effectively. Randomized clinical trials (RCT) and cohort studies indicated significantly better outcomes for

feedback conditions compared with treatment as usual(TAU) in individual (Lambert, 2015), couple (Anker, Duncan, & Sparks, 2009; Reese et al., 2010), family (Cooper et al., 2012), and group therapy (Schuman et al., 2015; Slone & Reese et al., 2015).

The PCOMS tools have the advantage of brevity, easy admission, and cost-effectiveness (Reese, Slone et al., 2013; Mikeal et al., 2016). Also, PCOMS supports a social justice paradigm via ongoing self-examination. PCOMS is used in mental health and substance abuse settings across the United States, Canada, Europe, and other countries (Anker et al., 2009; Reese, Toland, Slone, & Norsworthy, 2010), with over 1.5 million administrations in its database. PCOMS has been translated and used in the Netherlands (Hafkenscheid, Duncan and Miller, 2010; Janse et al., 2014), New Zealand (Bridgman, 2015), Norway (Sundet, 2012b), Spain (Gimeno-Peón et al., 2019), and Denmark (Østergård, Randa & Hougaard, 2018)**.** Duncan and Reese (2015) believe that PCOMS offers a culturally responsive process that can benefit clients of Color. Taking a broader view of the client feedback literature, current research has been predominantly conducted with non-Hispanic and White individuals (Minieri et al., 2015). More research is needed with samples that include racial/ethnic clients of Color to evaluate if client feedback is beneficial for them (Duncan, Reese, 2015).

Although some outcome research has been done in America among African Americans, Asian Americans, Hispanic/Latino Americans, and Native Americans (Cabral & Smith,2011), the mental health care provided to ethnic minority groups is inadequate, especially Chinese American communities (Lambert et al., 2006). Also, as the most populated ethnic group globally, only one outcome study is associated with PCOMS in a Chinese setting. Given the distinct differences between the Western and Eastern cultural norms in the actual process of building relationships

(Sun et al., 2017), more outcome-alliance research using Chinese samples is needed before a conclusion regarding the universality of the PCOMS (Sun et al., 2020).

Purpose of Research and Hypothesis

The purpose of this study is to evaluate the feedback effect on treatment outcome and client-therapist relationship and also investigate the effectiveness of PCOMS when it is used as an outcome measure in psychotherapy with Chinese clients. To understand PCOMS in terms of recommended methods of use, outcome, potential benefits, challenges, and limitations, I identify and review existing literature (Bellringer et al., 2019). The review starts with client feedback and feedback-informed treatment research, and then my review gets to four related questions. (1) What evidence is there of PCOMS improving treatment outcome and therapeutic relationship between clients and counsellors? (2) Has the use of PCOMS resulted in any unexpected outcomes for clients or treatment services? (3) How does PCOMS benefit different populations? Is it culturally appropriate for Chinese clients? If so, to what extent it helps Chinese clients. (4) How does PCOMS support counsellors in developing and demonstrating their skills and competencies?

First, I hypothesize that the routine track of clients' Outcome Rating Scale (ORS) and Session Rating Scale (SRS) scores will become significant evidence of predicting treatment outcomes and improving therapeutic alliance. Client improvement is the ultimate goal of therapy; tracking client improvement or deterioration through the collection of ongoing client feedback allows therapists to better tailor treatment in ways that meet clients' needs. Besides, the fair use of SRS at the end of each session enables clients' voice centered in sessions, and the client-therapist alliance gets strengthened when therapists choose approaches according to clients' theory of change (Mikeal et al.,2016). Second, I hypothesize that there are no unexpected outcomes when using PCOMS because the related studies are few. Third, I hypothesize that PCOMS benefits

different populations, although current empirical support is mostly from American and European White samples. PCOMS might not be culturally appropriate for Chinese clients, but it will be useful to some extent. Client feedback systems were developed primarily to reduce premature termination, and clients of Color have generally had higher rates (Kearney, Draper, & Barón, 2005). However, Reese, Duncan et al. (2014) had a benchmarking study and found no differences based on race/ ethnicity (Duncan & Reese, 2015; Minieri, Reese et al., 2015). Also, they evaluated the effectiveness of psychotherapy and found no significant differences in outcomes for the different ethnicities. PCOMS can facilitate the self-examination process by providing therapists with client-generated information about their practice. Therapists can then use this information to consider their effectiveness with different client populations (Duncan & Reese, 2015).

Finally, I also hypothesize that PCOMS benefits counsellors because it improves clients' outcomes. Counsellors can choose to discuss relevant client ORS and SRS data with their clinical supervisors and peers. Cultural competency and exploration of different treatment approaches can be involved in supervision as well. Also, Boswell, Kraus, Miller, and Lambert (2015) described the need for research to incorporate deliberate practice in cases where the PCOMS is used (Partridge & Dykeman, 2019). In summary, given the abovementioned, this thesis aims to conduct a preliminary investigation into how PCOMS influences clients' outcomes in feedback-informed treatment.

Definition of Key Terms

Common factors. It refers to the universal curative elements or ingredients shared by most psychotherapeutic models, such as therapeutic alliance, client characteristics, treatment structures, and hope/expectancy.

Client feedback. It is defined as the process of using standardized measures to systematically monitor client perception of the treatment process and outcome from session to session (Lambert, 2010).

Routine Outcome Monitoring (ROM). It involves regularly measuring and tracking client progress with standardized self-report scales throughout treatment and providing clinicians with this information before psychotherapy ends (Lambert, Hansen, & Finch, 2001; Newham, Hooke, & Page, 2010).

Negative outcomes. In the form of clients who deteriorate or experience little or no change, treatment is a severe problem in controlled research (clinical trials) and naturalistic studies (Slade, Lambert et al.,2008).

Feedback effects. It refers to the variability in client outcomes attributable to the use of outcome and alliance measures in-session as a form of feedback tool to guide treatment delivery.

Psychotherapist/Therapist/Counsellor/Practitioner/Clinician. These terms are used interchangeably to denote the primary person delivering the psychotherapy service.

Deliberate Practice. Focused and systematic effort to improve one's performance, pursued over extended periods, with a coach/mentor's guidance, and informed by the prompt feedback about their performance (Ericsson et al., 1993).

PCOMS. Partners for Change Outcome Management System.

OQ-45. Outcome Questionnaire-45.

ORS. Outcome Rating Scale.

SRS. Session Rating Scale.

Chapter Two

Psychotherapy Outcome

Today, both the efficacy and effectiveness of psychotherapy have been well established. Despite the consistent findings substantiating the field's worth, a significant question remains the subject of debate: *how does psychotherapy work* (Miller, Hubble et al., 2013)? One side is those who have long argued that psychotherapy is analogous to medicine. This group supports that different therapies are differentially effective, and specific treatments are more effective than nonspecific treatment-as-usual (TAU). The other side insists that any suggestion psychotherapy is comparable with a medical intervention is grossly inaccurate. Instead of focusing on specific methods, they insist that mechanisms common to all approaches, no matter the theory or technique, are responsible for the change.

After 50 years, these two groups tried to come to the center, and the hope has been that knowing how psychotherapy works would give rise to a universally accepted standard of care, which, in turn, would yield a more effective and efficient treatment. Fortunately, in the realm of psychotherapy, numerous well-established outcome measures are available to therapists for assessing their baseline. Nevertheless, though measures and norms are now widely available, surveys indicate that therapists expressed interest in having reliable outcome information. Still, few therapists use them in their day-to-day work (Miller, Hubble et al., 2013).

Outcome Measures

By the early 1970s, outcome research established various psychotherapy forms that had an overall positive effect on client outcomes (Lambert, Whipple et al., 2003; Lambert, 2007)**.** In the book *Assessing Outcome in Clinical Practice,* Ogles, Lambert, & Masters (1996) note that over

1400 measures are currently in use for measuring the effectiveness of psychotherapy, but choosing a measure to use can be challenging (Miller, Bargmann et al., 2011).

Being aware of the realities of clinical practice, and overcoming the obstacles to routine outcome measurement, Lambert's outcome management system has been approved as evidence-based by the Substance and Mental Health Services Administration National Registry of Evidence-based Programs and Practices (SAMHSA NREPP). Followed after Lambert's system, Miller and Duncan (2000) developed, tested, and disseminated two brief, four-item measures (Duncan et al., 2003; Miller, Duncan, Brown, Sparks, & Claud, 2003). The Outcome Rating Scale (ORS) and the Session Rating Scale (SRS) (Miller, S. D., Hubble et al., 2013). Moving Forward, Lambert, Duncan, and Miller's systems became the most popular outcome measures in this field. Admittedly, outcome measures identify and frequently quantify specific thoughts, feeling, and behaviors of the client at the time of administration. Compared with other data, observations, or previous results from the outcome measure, the client's changes can be noted (Mours et al., 2009).

Before Duncan and Miller, Lambert, Whipple, and their colleagues were the critical persons dedicated to outcome research. Lambert et al. (2003) applied client-focused research in his routine practice which demanded efficient outcome assessment rather than the more ideal alternatives of a comprehensive assessment. Outcome measurements typically employed in efficacy studies often require hours of assessment from multiple research, but client-focused research uses weekly assessments with a single, brief measure. Thus, assessment in this type of research was much more frequent, with a greater diversity of clients and sizeable final sample sizes. Lambert's (2007) investigation began with the development of a suitable but brief (5-10 min) outcome measure, the Outcome Questionnaire-45 (OQ-45; Lambert, Morton, et al., 2004), which provides both a measure of weekly change well as the criterion measure for classification

of a client into outcome categories after treatment. Lambert's (2007) decade long research results indicate that integrating treatment response research into routine mental health care reliably improved positive outcomes and reduced negative outcomes (Okiishi & Lambert, 2006).

Whipple and Lambert (2011) had a Meta-analytic review of six large-scale feedback studies using the OQ-45 outcome measure. Their review targeted efforts to use outcome measures in routine care to enhance psychotherapy outcomes, particularly for clients predicted to have a negative treatment outcome. This review suggested measuring, monitoring, predicting treatment failure, and providing clinical support tools to therapists enhanced treatment outcomes for clients who have an early negative treatment response (Lambert et al., 2003; Lambert, 2007; Whipple & Lambert, 2011).

To have a preliminary understanding of using outcome assessment measures, Mours et al. (2009) surveyed American Psychological Association accredited psychology internship training programs (N = 407) concerning their attitudes, beliefs, and practices about outcome assessment measures. The results indicated that 47% of surveyed sites use outcome measures for assessment; 79% of respondents supported using outcome assessment measures to evaluate client progress. Mours et al. (2009) implicated a strong need for standardized outcome assessment measures to be used in clinical practice as standardized outcome assessment has been an integral part of psychotherapy research for more than a decade.

Purpose of Measuring Outcome

Outcome research indicates that the general trajectory of change in successful psychotherapy is highly predictable, with most change occurring earlier rather than later in the treatment process (Miller, Duncan et al., 2006). Using outcome measures in a clinical setting can provide additional validation of a therapist's judgment and help therapists deliver better services

for their clients (Hatfield & Ogles, 2004). According to Ogles, Lambert, and Fields (2002), there are several reasons for conducting outcome assessments: such as to improve treatment, to enhance clinical science, to provide accountability, and to maintain the ethical responsibility of practitioners to examine the quality.

Prediction of a negative outcome**.** A key element in psychotherapy quality management research in defining and operationalizing the concepts of a positive and negative outcome for the individual client. Jacobson and Truax (1991) offered a methodology by which a client's change in outcome measure can be classified into four categories. Using this information, Lambert et al. (2003) placed clients in four categories in his Outcome Management System: Recovered (clinically significant change), Improved (reliably changed), No Change, and Deteriorated. Having a method to classify each client's treatment response is an essential component of outcome management. The primary purpose of psychotherapy outcome management is to understand and improve each individual's gains during treatment (Lambert, 2013). Therefore, Lambert et al. (2004) spoke to the fact based on his studies that Negative change, including No Change and Deterioration, can be predicted through Outcome Management System.

Whipple & Lambert (2011) examined and compared their work using the OQ-45 outcome measure with Hannan et al. (2005) study. In Hannan et al. (2010) study, therapists were asked to predict the eventual outcome of treatment with human judgment/diagnosis ability and virtually never correctly predicted deterioration. In contrast, Whipple & Lambert's study, based on using the OQ-45 outcome measure, made a similar prediction on clients. It showed that statistical methods are much more accurate than human judgment. Examples regarding the limitation of the therapist's ability to make correct judgments without feedback are plentiful. Though professionals are typically very confident about their eventual clinical decisions, Whipple

& Lambert (2011) predicted that in the future, such psychological “lab test” or “vital sign” data would be as standard and essential in behavioral health as in medicine.

Predicting treatment failures**.** As important as the choice of a specific measure, the primary characteristic of a useful measure is its ability to predict treatment failure accurately and identify at-risk cases. Although therapists are confident in their ability to care for clients in the absence of formal monitoring systems, it is apparent that the task of judging whether treatment response is adequate is a job best left to more systematic and standard methods.

To examine therapist accuracy in predicting poor treatment outcomes, Hannan et al. (2005) compared experienced therapists with trainees in predicting treatment failures and deteriorated clients. The result showed that their therapist predicted only three of 550 clients (0.01%). In general, the overall clients’ eventual deterioration was not forecasted by experienced therapists and trainees attempting to do so. This examination stated that several causes lead to therapists’ tendency to ignore the warning signs of treatment failure, and therapists have difficulty preventing treatment failure. Their perception of progress and outcome is at odds with measured mental health functioning. However, Lambert’s (2015) OQ-45 statistical method to predict treatment failure was well documented in five published studies; it suggested that between 85% and 100% of negative outcomes can be predicted well before treatment termination. So, prediction of treatment failure is too complicated for the human mind, and the apparent solution is to rely on scientific measures to identify potential treatment failures.

Indeed, measuring outcomes is useful for better service and has also been shown to improve individual therapists' success rates (Miller, 2010; Hubble, Duncan, Miller, & Wampold, 2009). Multiple independent randomized clinical trials (RCT’s) show that formally assessing and discussing the client’s experience of the process and outcome of care as much as doubles the rate

of reliable and clinically significant change experienced by clients, decreases drop-out rates by as much as 50%, and cuts deterioration by one-third.

Routine Outcome Monitoring (ROM)

Routine Outcome Monitoring (ROM) aims to enhance treatment outcomes by informing clients and therapists about the progress of psychotherapy (Boswell, Kraus, Miller, & Lambert, 2013; Lambert & Shimokawa, 2011). ROM appears especially significant for monitoring clients who are not doing well in therapy (Carlier et al., 2012).

Interest in the phenomenon of outcome measurement in routine care grew in the late 1980s with the emergence of cost containment efforts (Whipple, Lambert, 2011). Under the client-centered research system, Whipple, Lambert et al. (2003) found that clients in the feedback routine care group stayed in therapy longer and had superior outcomes than TAU (treatment-as-usual) group. Also, Lambert et al. (2003) had a meta-analytic review of three large-scale studies. They suggested that formally monitoring clients' progress significantly impacts clients who show a poor initial response to treatment. Moreover, Lambert and his colleagues indicated that therapists need to monitor clients' treatment response routinely and formally because more than a dozen randomized controlled trials and several meta-analyses have provided strong empirical support for routine outcome monitoring (ROM) in clinical practice (Miller, Hubble et al., 2015; Shimokawa, Lambert, & Smart, 2010).

The development of ROM systems during the past couple of decades has been an incredibly significant contribution to the psychotherapy field, improving practice, training, and research. The systems have become sufficiently wide-spread (Wampold, 2015; Goodyear, Wampold, et al., 2017). Although ROM-derived feedback does not guide specific behaviors or

interventions for the therapist to use, it can provide an important signal to examine therapy processes carefully and, in so doing, help therapists develop greater expertise.

Feedback-informed Treatment

Feedback Theory

The feedback, anchored against some criterion and relatively immediate, is essential for developing expertise. It is also necessary to reduce practitioners' overestimates of effectiveness (Walfish, McAlister, O'Donnell, & Lambert, 2012). Therapists can obtain that feedback from various sources, including their supervisor, coach, consultant, and clients (Goodyear, Wampold et al.,2017).

Feedback from outcome measures provides therapists and clients ‘‘with individual information on treatment outcome’’ based on outcome measures (e.g., mental health, symptom status, unmet needs). The mechanisms by which feedback may benefit treatment outcomes are still largely unclear. The most commonly suggested mechanism of impact draws on Feedback Intervention Theory (Kluger & De Nisi, 1996) and self- regulation theory (Scheier & Carver, 2003). These theoretical frameworks suggest that if a therapist and client accept the feedback as valid, a comparison is then made between actual and desired performance, such as between the current progress and expected recovery. A discrepancy may motivate therapists and clients to alter their behavior by, for instance, reformulating therapeutic goals (Carlier et al., 2012; Greenhalgh et al., 2013) or increasing adherence to treatment (Riemer et al., 2005). The discrepancy between actual and desired performance should mainly occur for clients who do not respond to treatment as expected. Therefore, these clients are expected to significantly benefit from feedback (Gondek et al., 2016).

Define Client Feedback

Client feedback is defined as the process of using standardized measures to systematically monitor client perception of the treatment process and outcome from session to session (Lambert, 2015). Duncan & Sparks (2017) defined Client Feedback as Progress Feedback. Client Feedback (progress feedback) refers to the continuous monitoring of client perceptions of benefit throughout therapy and a real-time comparison with expected treatment response to gauge client progress and signal when change is not occurring as predicted. With this alert, therapists and clients have an opportunity to shift focus, revisit goals, or alter interventions before deterioration or dropout.

Despite overall couple and family therapy efficacy, many clients do not benefit from treatment. Dropouts, poor judges of adverse outcomes, and grossly overestimate their effectiveness are problems (Duncan, Murray, 2012). Client feedback has developed a robust literature to support that it directly addresses these concerns (Lambert & Shimokawa, 2011). It has also been found to improve all clients' outcomes, not only for at-risk clients (Anker, Duncan, & Sparks, 2009; Reese, Norsworthy, & Rowlands, 2009; Shimokawa, Lambert, & Smart, 2010). Specific to psychotherapy training, client feedback has also been recommended for supervision to help supervisors monitor client well-being (Lambert & Hawkins, 2001; Minieri et al., 2015).

Evidence that Client Feedback (CF) can improve outcome is now well established. Randomized clinical trials (RCTs) and cohort studies indicate significantly better outcomes for feedback conditions compared with treatment as usual (TAU) in individual (Lambert, 2015), couple (Anker, Duncan, & Sparks, 2009; Reese, Toland, Slone, & Norsworthy, 2010), family (Cooper, Stewart, Sparks, & Bunting, 2012), and group therapy (Schuman et al., 2015; Slone, Reese et al., 2015). Client Feedback is especially useful in helping therapists identify the possible failure of ongoing treatment and collaborating with the client to restore positive outcomes (Norcross & Wampold, 2011; She, Duncan et al., 2018).

Introduction of Feedback-Informed Treatment

Implementing continuous feedback loops between clients and counselors has been found to have a significant impact on the effectiveness of counseling (Shimokawa, Lambert, & Smart, 2010). Feedback informed treatment (FIT) systems are beneficial to counsellors and clients as they provide therapists with a wide array of client information. Clients are plateauing in treatment, deteriorating, and at risk for dropping out (Lambert, 2010; Lambert, Hansen, & Finch, 2001); some information may be included, such as self-reported suicidal ideation, reported substance use, or other specific responses (Yates et al., 2016).

FIT systems are continual assessment procedures that include weekly feedback about a client's current symptomology and perceptions of the therapeutic process in relation to previous counseling session scores. Comparing clients' scores session to session, FIT systems provide a recovery trajectory, often graphed, that can help counsellors track the progress made through the course of treatment (Lambert, 2010; Prescott & Miller, 2015).

What kind of feedback matters? Although researches hugely directed the focus to predictions and treatment outcomes, Miller, Duncan, Brown, Sorrell, & Chalk (2006) published the results of a large study investigating the impact of providing regular, formal, ongoing feedback to therapists regarding their clients' experience of the quality of the therapeutic relationship and progress in care. The choice of "what" to measure was simple; the power of the therapeutic relationship was reflected in over 1,100 process-outcome findings (Duncan, Miller, Wampold, & Hubble 2009), making it the most evidence-based concept in the treatment literature (Miller, Bargmann et al., 2011).

To be practical, clients can complete a brief measure of their psychological function by using standardized rating scales, and then this information can be delivered to therapists in real-

time. In addition to alerting therapists to deviations from expected treatment response, clients' information provides novel information to therapists. Collecting this information from the client on a session-by-session basis provides the therapist with a systematic way of monitoring life functioning from the client's perspective. A brief formal assessment can provide a summary of life functioning that is not otherwise available to the therapist unless the therapist spends time within the treatment hour to systematically inquire about all the functioning areas covered by the self-report scale (Lambert & Shimokawa, 2011).

Several well-validated, reliable, and repeated feedback instruments exist. Still, only two have randomized clinical trials (RCTs) support. They are included in the Substance Abuse and Mental Health Administration's National Registry of Evidence-Based Programs and Practices (NREPP) (Yates et al., 2016). The first one is OQ Psychotherapy Quality Management System, developed by Lambert (2004) and colleagues. Michael Lambert is the pioneer of systematic feedback, evolving the idea of outcome measurement to a 'real-time' feedback process with a proven track record of improving outcomes (Duncan & Sparks, 2016). The central measure is the OQ-45, a 45-item, self-report measure designed for repeated administration throughout treatment and termination with adult clients. The second one is Partners for Change Outcome Management System (PCOMS; Miller, Duncan, Sorrell, & Brown, 2005), is a psychotherapy assurance system that employs two brief scales (Lambert & Shimokawa, 2011). These two systems have gone beyond measuring progress and outcome, investing considerable energy in collecting and feeding back client ratings of their therapist in the hopes of maximizing the final treatment outcome (Schuckard, Miller, & Hubble, 2017).

Various practices and organizations use FIT systems differently within the counseling field. Although some deviations exist, all feedback systems contain consistent procedures

commonly employed when utilizing a system during practice (Lambert, Hansen, & Harmon, 2010). The first procedure in a FIT system includes the routine measurement of a client's symptomology or distress during each session. The second procedure of a FIT system includes showcasing the results of the client's symptomology or distress level in a concise and usable way. The last FIT system procedure consists of adjusting counseling approaches based upon the feedback (Tilsen & McNamee, 2015).

Effects of Client Feedback on Outcome

Deterioration and dropout. Psychotherapy outcome research has shown that a significant number of clients do not make progress as expected in treatment and, as a result, are at risk for deterioration and drop out (Lambert & Ogles, 2004). There are some significant study findings from Lambert and his partners.

Lambert et al. (2003) meta-analysis study found that feedback (vs. no feedback) yielded an effect size of 0.40, with deterioration rates decreasing from 21% to 13% and reliable/clinically significant change rates increasing from 21 to 35%. Later on, another meta-analysis suggested that clients in a Feedback condition deteriorate at a rate of approximately 4-5% (Lambert et al., 2004), which is an improvement over deterioration rates in the overall psychotherapy outcome literature (Lambert & Ogles, 2004).

Harmon, Lambert et al. (2007) examined reducing client deterioration in a sample of 1,374 clients whose outcome was contrasted across experimental groups and with a no-feedback/ archival control group consisting of data from 1,445 clients. The result indicated that feedback to therapists reduced deterioration rates and improved outcomes across clients, especially those predicted to be treatment failures.

Lambert (2013) reviewed nine controlled studies using feedback measures. His meta-analysis combined data from six well-designed clinical trials that compared TAU to feedback-assisted treatment in which the same therapist offered both conditions to over 4,000 clients. Results indicated that feedback to therapists and clients had a powerful effect over TAU with cases that were predicted to be treatment failures (20%-30% of clients). The deterioration rate was reduced by 50% (to 9%) and the increased positive outcomes from 22% in TAU to 38% in the feedback condition (Lambert, 2013). These figures replicated Lambert's (2011) meta-analysis finding that the number of psychotherapy clients who deteriorate can be cut in half using OQ-45 or PCOMS systems (Lambert & Shimokawa, 2011).

Effects of Feedback on Therapeutic Alliance

Bordin (1994) suggested the alliance in the early stages of treatment is built principally on a positive *emotional bond* between therapists and clients (such as trust, respect, and liking). Therapists and clients' ability to agree on the treatment goals and their establishment of a mutual consensus on the tasks (e.g., homework, Socratic dialogue, free association) that form the substance of the specific therapy (Norcross & Wampold, 2011). Goodyear et al. (2017) suggested that the alliance is a vehicle used to create expectations and is necessary for clients to enact psychotherapy rituals, which lead to the enactment of health-promoting actions. Moreover, the bond in the alliance is quite similar to the real relationship. That is to say, and the alliance seems to be central to therapeutic change, an observation strongly supported by the research evidence. The alliance has been defined in several different ways, but the core consensus among these definitions is that the alliance is an emergent quality of partnership and mutual collaboration between therapist and client.

More than 100 published articles supported the idea of the therapeutic relationship as a significant predictor of the outcome (Harmon, Lambert et al., 2007). Miller, Bargmann et al. (2011) stated that the single largest contributor to treatment success is the relationship between client and therapist regardless of treatment approach. In Stargell's (2017) quantitative study, counsellor and client pairs from a university training clinic were analyzed. It showed that the therapeutic relationship accounted for 25% of the overall variance in outcome effectiveness. This study supports the idea that the therapeutic relationship is positively related to counseling outcomes and can be intentionally improved across time.

As strong as the research is relative to the alliance, it might be that it is the client's contribution to the alliance that is important. However, just the opposite has been found. Baldwin, Wampold, and Imel (2007) disentangled the therapists' and the clients' contributions to the alliance and found that only the therapists' contribution to the alliance predicted outcome, a result confirmed meta-analytically. It is what therapists offer clients in terms of forming an alliance that produces better outcomes. The conclusion from this research is unequivocal: *Effective therapists form strong alliances across a range of clients* (Rousmaniere, Goodyear et al., 2017).

Partners for Change Outcome Management System (PCOMS)

Theories

Psychotherapy is a double-edged sword. The advantageous side is that therapy works; the average treated person is better off than about 80% of the untreated sample. The disadvantageous side is that many clients do not benefit despite overall efficacy. Dropouts and poor judges of negative client outcomes are problems, and therapists vary significantly in success rates without knowing their effectiveness (Duncan & Sparks, 2015). As mentioned in Feedback-Informed Treatment, several client feedback systems have been developed to identify at-risk clients and

track outcomes in psychotherapy (Mikeal et al.,2016). Although these systems have been adopted for use in a variety of health care settings, there have been concerns, such as therapists' noncompliance (Hanlon, 2005; Stiles, Barkham, Connell, & Mellor-Clark, 2008) and some time-consuming measures for routine in-session use (Duncan, 2014; Miller, Duncan, Brown, Sparks, & Claud, 2003). To address these practical considerations and to make routine use of feedback more feasible, Duncan and colleagues (Duncan, 2014; Duncan, Miller, & Sparks, 2004; Miller, Duncan, Sorrell, & Brown, 2005) developed the Partners for Change Outcome Management System (PCOMS).

PCOMS is one approach of what is called *systematic client feedback* (Duncan & Sparks, 2015). Although systematic feedback systems vary significantly in clinical processes and the measures used, all share the desire to measure the client's response to service and to feed that information back to the therapist (or to both client and counsellor) for the possibility of a positive outcome (Duncan & Sparks, 2017).

The *pluralistic practice* is an approach to therapy based on a pluralistic perspective that draws on techniques from multiple orientations and is characterized by ongoing negotiation with clients about the goals, tasks, and treatment methods. PCOMS operationalizes a pluralistic approach in several ways. First, PCOMS does not drag any theoretical baggage to the therapeutic journey, and it neither explains client problems nor offers any solutions. PCOMS is consequently pluralistic in its scope and encourages an individually tailored therapy that emerges from the client's idiosyncratic strengths, cultural worldview, and theory of change (Duncan, Solovey, & Rusk, 1992). When services are provided without intimate connection to clients and their responses and preferences, clients become cardboard cut-outs and the object of our professional deliberations. Valuing clients as credible sources of their own experiences of progress and

relationship allows clients to teach us how to be the most effective with them, consistent with a pluralistic perspective (Duncan & Sparks, 2015; Miller & Duncan et al., 2005).

Framework of PCOMS

PCOMS was designed to be a briefer alternative to other methods of obtaining client feedback, and it is evolved from its communicative origins to a system accomplishing key normative objectives (Spark, Duncan, 2018). It is comprised of two four-item measures that monitor treatment outcome and the therapeutic alliance. Each of the four primary instruments contains the basic PCOMS measurement set, the ORS, SRS, CORS, and CSRS. The ORS and SRS are used with adults and adolescents aged 13–17. Children aged 6–12 use the CORS and CSRS. Adult caregivers provide feedback for their child or adolescent on either the CORS or ORS based on the child's age. The ORS and CORS are administered at the beginning of every session, either via paper/pencil or iPads/tablets. Clients place a mark or move a cursor on each line according to their perception of how they are doing (or how they perceive their child doing) on each dimension of the ORS or CORS. The SRS and CSRS are administered during the last 5 minutes of a session (Spark, Duncan, 2018). Because of the desire to create a system feasible for everyday clinical practice, PCOMS instruments are brief, generally requiring no more than 3 to 5 minutes to administer, score, and discuss.

The Outcome Rating Scale (ORS) is modeled after the domains of outcome measured by the subscales of the Outcome Questionnaire-45 (OQ-45, Lambert, Morton, et al., 2004). It evaluates four dimensions: "(1) Individual – personal or symptomatic distress or well-being; (2) Interpersonal – relational distress or how well the client is getting along in intimate relationships; (3) Social – the client's view of satisfaction with work/school and relationships outside of the home; (4) Overall – a general sense of well-being" (Duncan, 2012, p. 94). The ORS measures each

item using a visual analog format of four 10-cm lines; clients "place a mark on each line with low estimates to the left and high to the right" (Duncan, 2012, p. 94). The score on each item is measured to the nearest millimeter using a ruler or template and then are summated for a total score. Scores range from 0 to 40, with lower scores indicating more distress. The ORS is completed and scored at the beginning of each session, and scores are then discussed with the client (Yates et al., 2016).

The Session Rating Scale (SRS; Duncan, 2011**)** is designed for the client to assess the therapeutic alliance. It is the SRS administration toward the end of each session and the discussion of client perceptions about the alliance. The SRS is also a four-item visual analog scale based on Bordin's (1979) classic delineation of the alliance's components: the relational bond and the degree of agreement between the client and therapist about the goals and tasks of therapy. Clients place a mark on a 10-cm line nearest the pole that best describes their felt experience with their therapist. Specifically, the instructions of the SRS direct clients to rate their therapists on the following items: (1) Relationship with the therapist ("I felt heard, understood, and respected"); (2) Goals and topics ("We worked on or talked about what I wanted to work on or talk about"); (3) The approach used in therapy ("The therapist's approach is a good fit for me"); (4) The overall rating of the session ("Overall, today's session was right for me"). The client's marks on the four items are measured with a centimeter ruler and totaled for a score ranging from 0 to 40.

Practical Use of PCOMS. The PCOMS manual (Duncan, 2011) provides a cut-off score for both measures (ORS cut-off score is 25 for adults, meaning those below 25 are considered in the clinical range for distress. SRS cut-off score is 36, indicating that scores below this threshold may indicate a problem with the therapeutic alliance), a reliable change index for the ORS (6 points), and a rubric to assist clinical decision-making for monitoring outcome progress. Research

evidence has supported the reliability and validity of both measures (Minieri et al., 2015; Yates et al., 2016). Because of its brevity, PCOMS is therapist-friendly and ensures discussion of assessment results by the client and therapist in session (Lambert & Shimokawa, 2011). Usually, therapists use PCOMS scales to start a conversation with the client and then use PCOMS to evaluate client progress and the therapeutic relationship. The PCOMS graph of scores over time allows clients to visually see their progress and facilitate more in-depth topics on their progress.

Predictors. The PCOMS embraces two known predictors of ultimate treatment outcome. Time and again, studies reveal that the majority of clients experience the majority of change in the first eight visits (Baldwin, Berkeljon, Atkins, Olsen, & Nielsen, 2009). Early on, clients who report little or no progress will likely show no improvement over the entire therapy course or end up on the drop-out list. Monitoring change provides a tangible way to identify those who are not responding so that a new course can be charted. A second robust predictor of change solidly demonstrated by a large body of studies is the therapeutic alliance. Clients who highly rate their partnership with their therapists are more apt to remain in therapy and benefit from it (Duncan & Sparks, 2016; Duncan & Sparks, 2017).

Although PCOMS is designated as an evidence-based practice, it is not a specific treatment model for a client's particular diagnosis. PCOMS has demonstrated significant improvements for both clients and counsellors regardless of therapists' theoretical orientation or client diagnosis. More importantly, PCOMS is evidence-based at the individual client–counsellor level, promoting a partnership that monitors whether the therapist's approach benefits this client. In other words, it is *evidence-based practice one client at a time* (Miller & Duncan et al., 2005; Duncan & Sparks, 2017).

Empirical Support of PCOMS

Miller, Prescott, and Maeschalck (2017) provided a comprehensive review of all ORS and SRS research. Here, findings from several representative studies documenting the effectiveness of the system in individual, couples, and group therapy are reviewed. These studies have overall effect sizes ranging from d = 0.28 (group therapy) to 0.54 (individual therapy). These effects are comparable to the well-researched OQ System (Lambert & Shimokawa, 2011). Research utilizing the ORS and SRS has consistently found that clients receiving feedback experience numerous benefits in psychotherapy, most notably a doubled overall effect size in their progress compared with clients who received treatment as usual (TAU).

PCOMS in individual therapy. The current study from Mikeal (2016) used a dismantling design to investigate the relative efficacy of components of the PCOMS. The finding suggested that using either the ORS or SRS component of the PCOMS may yield equivalent outcomes to the full PCOMS.

Reese, Norsworthy, and Rowlands (2009) conducted two randomized clinical trials on PCOMS in a university counseling center and a graduate training clinic. In both settings, clients in the feedback condition had significantly better outcomes than those in the no-feedback condition. Moreover, significantly more participants in the feedback condition met the criteria for reliable clinical change (i.e., an improvement of at least 5 points on the ORS). Unlike the use of the OQ-45, the ORS and SRS's use was associated with improved outcomes for cases that were not progressing.

Reese, Duncan, Bohanske, Owen, and Minami (2014) focused on whether PCOMS works with more distressed and impoverished clients. To do this, they compared the effectiveness of ORS feedback from clients in a large behavioral health center that served lower-income and more distressed clients with the efficacy of other large-scale research studies for clients with

depressive disorders. Results document that the outcomes of such clients were comparable to the benchmarks set in clinical trials. Besides, three benchmarking studies have found outcomes comparable with RCTs in settings that have implemented PCOMS with adults and children in a public behavioral health setting (Kodet, Reese, Duncan, & Bohankse, 2017; Reese et al., 2018), as well as with clients in an acute psychiatric unit.

Brattland et al. (2018) randomly assigned 161 clients in a mental health clinic to either routine outcome monitoring or treatment as usual groups. In the routine outcome monitoring condition, therapists used PCOMS to measure and give feedback on outcomes to clients. Clients who received routine outcome monitoring were 2.5 times more likely than treatment as usual clients to show improvement as measured by another outcome measure, BASIS-32. The pre-post effect size was d = 0.42, which is considered a small to medium effect size (Buchanan, 2019).

PCOMS in couple therapy. One of the two progress feedback interventions included in the Substance Abuse and Mental Health Administration's (SAMHSA) National Registry of Evidence-based Programs and Practices is the Partners for Change Outcome Management System (Duncan, 2012). The Partners for Change Outcome Management System (PCOMS) has demonstrated significant improvement in outcomes with couples and families (Duncan & Sparks, 2017).

Two studies have been conducted on the use of PCOMS in couple therapy, one in Norway (Anker, Duncan, & Sparks, 2009) and the other in the United States (Reese, Toland, Slone, & Norsworthy, 2010). Couples in both studies were randomly assigned to either the feedback or the no-feedback condition. In both studies, couples in the feedback condition had significantly better outcomes than the no-feedback couples. Anker et al. (2009) found that the difference in outcome continued at a 6-month follow-up on the ORS, meaning that couples who provided

feedback to their therapist were significantly less likely to separate or divorce (18.4% separation rate compared to no-feedback couples' 34.2% separation rate) 6 months after the study ended. Hannan and colleagues (2005) found that 944 predictions therapists made regarding who in their caseloads would worsen in treatment, but only three predictions were that clients deteriorated, and one of those three was accurate.

PCOMS in group therapy. Two studies have evaluated the use of ORS in group therapy. Schuman, Slone, Reese, and Duncan (2015) examined whether feedback via the ORS led to improved client outcomes, less deterioration, and lower rates of clients leaving before therapy was completed among a sample of Army soldiers referred to an outpatient group tailored for substance use. Slone, Reese, Matthews-Duvall, and Kodet (2015) evaluated the full PCOMS with a sample of college students in interpersonal process groups at a university counseling center. In both studies, clients in the feedback conditions had better outcomes and were also more likely to have achieved clinically reliable change. Additionally, clients in the feedback conditions were less likely to terminate prematurely (Schuman et al., 2015) and attended significantly more sessions than clients in the no-feedback groups.

PCOMS in supervision and training. The use of client PCOMS data during clinical supervision may be a way to enhance therapist development. Lambert and Hawkins (2001) were the first to suggest that supervision could use client outcome data to discuss client progress and inform future treatment. Further, they asserted that client outcome data could help shape how time in supervision was spent, providing information to facilitate training, and ensuring that clients benefit.

Minieri, Reese et al. (2015) outlined how PCOMS in psychotherapy and supervision can serve as a useful training tool that is a form of evidence-based practice (EBP) and promotes a

socially just paradigm in psychotherapy. They also offered an implementation example from a counseling psychology doctoral program to demonstrate how PCOMS can be used with clients in psychotherapy and included within the supervisory process.

Duncan and Reese (2015, 2016) regarded the use of PCOMS-identified client cases in the supervision process to be important as this brings client voice into supervision. Moving away from the tradition of therapist selection of clients to discuss with their supervisors, clients are selecting themselves on account of their ORS scores and their non-progress (Duncan & Reese, 2015, 2016). Duncan (2016) clarified that what makes PCOMS-based supervision different from other methods is its emphasis on clients. PCOMS supervision aims to improve outcomes via identifying at-risk clients, then focuses on the supervisee and professional development using ORS data as an objective standard of effectiveness over time. However, only a few studies have investigated the outcomes of using client PCOMS data in clinical supervision.

Miller, Duncan, Brown, Sorrell, and Chalk (2006) conducted the first study of PCOMS in training from therapists' perspectives. A clinical center implemented PCOMS, and client outcomes significantly improved from intake to termination, an effect that doubled in size when therapists had been using PCOMS in their practice for more than six months. Besides, when therapists had access to SRS data, their clients were three times more likely to return for another session than clients of therapists who did not have access to SRS data. A critical validation of the value of PCOMS came from the therapists themselves: One year after their PCOMS training, 99% of the therapists at this center continued to use feedback measures regularly with clients (Rousmaniere, Goodyear et al., 2017).

Nonsignificant Feedback Effect Findings

Despite considerable positive support of PCOMS, four studies have found mixed or nonsignificant feedback effects. Murphy, Rashleigh, and Timulak (2012) found a non-significant advantage for the use of the ORS in total change (6.41 vs. 4.69 points) as well as the number of clients reaching reliable change (36 or 61% of the sample of 59 versus 24 or 47% of a sample of 51).

Second, in a large (N =1,006) non-equivalent group design, a study addressing whether PCOMS improved outcomes and efficiency of cognitive-behavioral therapy, Janse, de Jong et al. (2016) found no advantage of PCOMS on the Symptom Checklist Revised-90. An advantage was found as measured by the ORS, and clients in the feedback condition achieved change in significantly fewer sessions. A post-study audit revealed that 23.2% of the charts had no evidence of PCOMS use.

Third, an investigation addressing PCOMS in emergency psychiatry (van Oenen et al., 2016) found no differences between the ORS and the OQ. A post-study survey revealed that only 67% of the therapists applied PCOMS in more than 70% of the sessions.

Finally, with a sample of single female clients diagnosed with eating disorder in group psychotherapy (N =159), Davidsen et al. (2017) found no significant differences between PCOMS and TAU on attendance, eating disorder symptoms, and the ORS. A survey of participant therapists revealed that therapists did not discuss PCOMS feedback with clients and did not find it useful. Therefore, to address the mixed results of these four European investigations, the current study attempts to mitigate the effects of both non-adherence and negative therapist perceptions of usefulness.

PCOMS with Chinese Clients

Ethnicity describes groups in which members share a cultural heritage from one generation to another. *Culture* has been defined as the integrated pattern of human behavior that includes thoughts, communication, action, customs, beliefs, values, and instructions of a racial, ethnic, religious, or social group (Day-Vines et al., 2007).

Few studies have examined PCOMS and its recommended use for different ethnicities and cultures. Reese, Duncan, Bohanske, Owen, and Minami (2014) evaluated the effectiveness of psychotherapy services for individuals of lower socioeconomic backgrounds (n=5,168) by a public behavioral health service in Arizona, USA. As demonstrated in pre-post ORS scores, no significant differences in outcome were found for the different ethnic groups (i.e., Hispanic, African American, Native American, Asian American, and Euro-American; Reese et al., 2014). Although this suggested suitability across ethnicities, Manthei (2015) cautioned that possible cultural and national differences in ORS and SRS scores across countries should be considered and noted that the scales' cultural neutrality had been taken for granted in several countries. Manthei (2015) also pointed out that the ORS and SRS scales have been translated and used in different languages based on the assumption that the USA clinical cut-off scores are internationally applicable.

Feedback Effects on Outcome

Although client feedback has been demonstrated to improve psychotherapy outcomes in over a dozen randomized clinical trials, only two RCTs studies investigated the feedback effect outside of the United States or Europe (She, Duncan et al. (2018). The first one was in Singapore with most clients from Chinese cultural backgrounds; the other was conducted in mainland China followed by secondary data analysis.

She, Duncan et al. (2018) had the first study to demonstrate the effects of improved outcomes and efficiency associated with a client feedback intervention in a Mandarin setting. This

study examined the impact of a client feedback intervention, the PCOMS, in a college counseling center in Wuhan, China (N = 186). Using a randomized design in routine care, the treatment as usual group (TAU; n = 85) was compared with a feedback condition (n = 101) in which therapists had access to client-generated outcome and alliance information at each session. Clients in the feedback condition demonstrated significantly more significant improvement than those in the TAU condition at posttreatment. Not-on-track (n = 60) clients also showed considerably more improvement at six times the rate of reliable change than the TAU condition. Survival analysis revealed that 66.7% of the clients in the feedback condition achieved reliable and clinically significant change after a median of 4 sessions, whereas 57.0% of clients in the TAU condition achieved reliable and clinically significant change after a median of 6 sessions. Alliance scores improved significantly more across treatment and were higher at posttreatment in the feedback condition. Although preliminary, this study suggests that the positive effects of improved outcomes and increased efficiency associated with systematic client feedback can also occur in a college counseling setting in China.

She, Duncan et al. (2018) conducted their study in a college counselling setting similar to Reese, Norsworthy, and Rowlands' (2009) work. Their findings corroborate the effects in other PCOMS trials (Duncan & Reese, 2015) that reported significant feedback over TAU with both the not-on-track and overall samples. Also, the effect size (ES) findings were consistent with the Lambert and Shimokawa (2011) meta-analysis of PCOMS studies. However, the results were not consistent with some PCOMS trials, but "adherence" may suggest an explanation. Adherence and therapist perceptions of usefulness have emerged as necessary to the feedback effect. Adherence may be particularly crucial to the PCOMS feedback effect, and the PCOMS is intended to be used to discuss outcome and alliance with clients in session. Therefore, PCOMS is a monitoring system

to inform the therapist and requires discussion and collaboration with clients. Such a process creates a higher demand for the therapist to incorporate the feedback.

Chow & Huixian (2015) examined the impact of ROM (Routine Outcome Monitoring) by using PCOMS in an Asian outpatient psychiatric hospital in Singapore (most are Chinese). This study had outpatients (N=178) been signed to either a No-Feedback (NFb) and Feedback (Fb) group. The Outcome Rating Scale (ORS) and the Session Rating Scale (SRS) were used at the start and end of each session, respectively. FB group discussed and provided feedback about their progress at every session, while the therapists in the No Feedback (NFb) group were blind to the ratings. The same four therapists were used in both groups. The study result showed that the Fb achieved higher clinical improvements than NFb in terms of magnitude of change (Effect Size NFb=0.72; Fb=1.0), reliable improvement (NFb = 52.6%; Fb = 59%), and reliable recovery rates (NFb =31.6%; Fb = 39.7%). There was also a reduction of drop-out rates after the first session (NFb =28.8%; Fb = 19.4%), and deterioration rates (NFb =12.3%; Fb = 3.8%). Chow & Huixian's (2015) study provided preliminary evidence that using PCOMS in ROM has therapeutic benefits in an Asian context. However, the effects are more modest than past evidence (Miller, Hubble, Chow, Seidel, 2013). Nevertheless, the use of ROM can serve as a stepping stone in developing a culture of excellence in improving therapy outcomes.

Alliance-Outcome Relations

Flückiger et al. (2018) meta-analysis indicated that the working alliance is one of the most investigated and critical factors for successful psychotherapy. However, it has been noted that the alliance-outcome research is established mainly based on empirical evidence drawn from Western contexts (Sun, Wu et al., 2020). Besides positive outcomes, She, Duncan et al. (2018)’s study also found a significantly higher post-treatment alliance score and faster growth of SRS scores across

treatment in the PCOMS condition. It suggested that attending to the alliance may influence the feedback effect. The hypothesis regarding premature termination was partially supported, and significantly fewer clients dropped out of treatment in the feedback condition for the intent-to-treat (ITT) sample.

Most recently, Sun, Wu et al. (2020) had a secondary data analysis from She, Duncan et al. (2018), it examined the alliance-outcome relation and the possible moderation effect of receiving progress feedback on a sample (N=159) of Chinese clients from a university counselling center. Participants were randomly assigned to either the progress feedback group or the non-feedback group. Therapists working with clients in the feedback group received their clients' SRS and ORS scores weekly and were asked to plot their scores in a chart. The alliance-outcome and moderator effects were tested with disaggregated cross-lagged panel modeling of SRS and ORS. The findings indicated a robust reciprocal relation between SRS and ORS, but the moderator effect due to feedback was not supported. Results affirm the cross-cultural stability of the session-by-session reciprocal effects of the alliance-outcome model in a Chinese sample. This study can be seen as a cross-cultural replication of the alliance-outcome findings established with Western samples. The final models supported by the data suggest that psychological distress influences the working alliance negatively. The more distressed a client is when coming to a particular therapy session, the more difficult the therapist-client collaboration will be in that session. However, if the therapist manages to collaborate with the client through the therapy process, it reduces the client's suffering until the next session. Moreover, the reduction of symptoms also contributes to the perception of a stronger alliance in the next session.

Sun, Wu et al. (2020) suggested that the reciprocal influence model may be stable across cultures. Although there have been a few studies conducted outside Europe, North America, and

Australia/New Zeeland, more research with non-Western samples is needed to examine the universality of the positive alliance-outcome relationship.

Considerations

Chinese cultural context. The Chinese culture is generally considered relationship-oriented and socially focused, emphasizing family loyalty, deference to authority, and social conformity. ‘‘We’’ oriented (vs. ‘‘I’’ oriented) and interdependent (vs. independent) is traditionally valued. Besides, being polite, humble, and appreciative is seen as a virtue. This cultural context of humility and deference has been discussed as the basis for the attitudes toward psychotherapy of Chinese clients (Duan, Hill et al., 2012). Being influenced by Confucian ideas, the Chinese are taught to obey their parents, respect elders, and restrain themselves in order to keep family harmony. Such schemas are subsequently transferred to their social life in the form of respecting authority/superior, maintaining interpersonal peace, and saving face (Sun, Wu et al., 2020).

Duan, Hill et al. (2012) suggested that rather than client implementation of therapist directives influencing the outcome, directives seemed to make Chinese clients feel better about the therapist’s expertise and thus created a stronger alliance with the therapist, which led to a positive outcome. These findings echo previous studies on Asian American students (Hill et al., 2007; Kim & Atkinson, 2002) that Asian clients like directives but do not necessarily lead to specific behavior changes.

Qian, Smith, Chen, and Xia (2002) noted that Chinese clients tend to distrust the effectiveness of talk therapy and expect the therapy process to be similar to medical treatment. The doctor gives explicit directions for fixing client problems. Furthermore, the fear of ‘‘losing face’’ by seeking help would prompt Chinese clients to complete therapy as quickly as possible. Qian et

al. (2002) also proposed that clients might listen deferentially to therapist directives but not implement these directives into their lives.

Cross-cultural difference. Although most studies using the OQ and PCOMS have been conducted in the United States or Europe; She, Duncan et al. (2018) examined the impact of client feedbacks in a college counseling center in mainland China. Significant cultural differences regarding therapy could impact the effects of feedback. PCOMS, by design, is intended to be transparent and collaborative, promoting a more egalitarian therapeutic relationship, raising the question of whether it would realize the same benefits in China. For example, could the PCOMS confuse the traditional hierarchy and result in no feedback effect or even less change?

In She, Duncan et al. (2018) study, a departure from the typical PCOMS protocol of the therapist administering and discussing the ORS and SRS in session, all measures were given by administrative staff separate from the therapy encounter. She, Duncan et al. (2018) made the change to honor potential cultural differences in this setting and therapists' views of those differences. Therapists were surveyed before the study, and a majority were in favor of collecting feedback outside of the therapy. This study indicated that the adapted protocol of the PCOMS might be an advantage when used in the Chinese cultural setting. Another point was noteworthy that the average first session SRS score was lower than U.S. or European samples, somewhat contrary to what cultural differences might predict. More research is needed to investigate this difference as well as the mechanisms in the feedback effect.

Sun, Wu et al. (2020) considered Chinese cultural context in their analysis. Because it was a common practice for Chinese clients to communicate negative attitudes later and indirectly, especially with social figures with a higher status (e.g., therapists) that they are expected to show respect to (Hwang, 2000). Such implicit communication is a Chinese norm of "face-saving" in

social interactions and indicates that therapists should take effort to discern and attune to clients' unexpressed needs and wishes (Kuo et al., 2011). Sun, Wu et al. (2020) also experienced that Chinese clients often expect expert opinions or a directive counseling style (Duan et al., 2012; Sun et al., 2017), which may hinder their responsibility and involvement in psychotherapy.

Based on a pilot study results about therapists' attitudes to feedback, Sun, Wu et al. (2020) finally used a culturally adapted feedback procedure. The protocol for the feedback group used in this study must be different from the standard procedures of the PCOMS. In their study, the therapists did not administer SRS/ORS themselves and were not forced to discuss SRS/ORS scores with their clients in the session of receiving the information. Using indirect communication, therapists and their clients can maintain a cooperative relationship with each other without directly dealing with relationship strains, which may imply losing face. Sun, Wu et al. (2020) believe progress feedback can play a critical role in facilitating the rupture-repair process in psychotherapy in China.

Translation equivalence. Because of many cultural factors, a contentious issue in cross-cultural assessment is the cultural and linguistic equivalence of measures, particularly those relying on self-report. Self-report tests have a firm reliance on language that can be problematic with translations and the originals administered to cultural group members whose first language is not English (Wan, 2001).

CORE (Clinical Outcomes in Routine Evaluation) is a self-report outcome measure similar to PCOMS. Wan (2001) investigated the generalisability of the CORE (Clinical Outcomes in Routine Evaluation) measure to the Chinese community in Britain by (1) comparing outcome scores from the non-clinical Chinese population with existing normative data; and (2) comparing outcome scores from a translated version with the original. One hundred and thirty-three non-

clinical Chinese participants residing in Britain responded to either the original measure (CORE; *n*=104) or a Chinese translated version (C-CORE; *n*=29). The Chinese sample, whose CORE scores also demonstrated test-retest and internal reliability, did not differ significantly from the white Europeans. However, C-CORE respondents produced substantially higher overall scores (indicating poorer well- being) than the CORE group. The study suggested the design modification for clients of color and the need for recognizing cultural difference (Wan, 2001).

Admittedly, multiple psychometric studies and RCTs have validated the reliability and validity of English ORS (Duncan & Reese, 2015). Hundreds of thousands of administrations have determined ORS cut-off score and reliable change norms (Duncan & Sparks, 2017). The Chinese version of the ORS used in She, Duncan et al. (2018) and Sun, Wu et al. (2020)'s studies demonstrated right internal consistency (a=0.84) and moderate concurrent validity (r=0.60) with the OQ with similar samples (She, Sun, & Jiang, 2017), and consistent with other psychometric studies of the English-based ORS and OQ (Duncan & Reese, 2015). The English SRS also generated reliable and valid scores in both psychometric and RCT investigations (Duncan & Reese, 2015). Regarding the SRS cut-off score, a conservative estimate derived for clinical purposes with descriptive statistics (score at which most clients are above) is 36 (Anker et al., 2009). In She, Duncan et al. (2018) and Sun, Wu et al. (2020)'s studies, the Chinese SRS has not been validated, but the internal consistency in the current study (a=0.93) is similar to other studies.

As the above studies implicated, a fundamental requisite for accurate translation is equivalent terms in the new language. Wan (2001) argued that a lack of equivalence could also bring problems if minority members whose first language is not English use an English-language scale as they may lack the cognitive structure for the concept. Some research shows that no equivalent Chinese words are available for some commonly used English emotional terms such as

'concern.' Chinese people tend to use relatively few expressive words when talking about their relations. Therefore, translation accuracy and equivalence play a significant role when using outcome measures, like PCOMS, cross-culturally, and further research is much needed.

Therapist-client matching. Therapist-client matching generally refers to clients' preference for a therapist of the same race/ethnicity. Overall, the research in this area has been mixed, with research supporting and not supporting the notion that the matching supports improved client outcomes. The importance of therapist-client matching could be related to the client presenting problem. Pope-Davis et al. (2002) found that clients for whom cultural concerns were strongly related to their presenting concerns prefer therapists matching them in terms of race/ethnicity and gender; however, those clients whose presenting concerns were not related to cultural issues were less worried about therapist-client matching (Miserocchi, 2014). Therapist-client matching consideration did not apply to She, Duncan et al. (2018) and Sun, Wu et al. (2020)'s studies because both therapists and client samples shared the same culture and language; however, Chow & Huixian (2015) did not mention this element in their study.

Chapter Three

Discussion

The purpose of this study is to evaluate the feedback effect on treatment outcome and client-therapist relationship, and also investigate the effectiveness of PCOMS when it is used as an outcome measure in psychotherapy with Chinese clients. To understand PCOMS in terms of recommended methods of use, outcome, potential benefits, challenges, and limitations, I identified and reviewed existing literature. The literature review started with outcome research and Lambert's great work in Routine Outcome Monitoring (ROM), and moved to Miller and Duncan's innovative feedback measures on Feedback-informed Treatment and PCOMS, then focused on the

effectiveness of PCOMS on Chinese clients. The specific aims of this study were to answer these questions. (1) What evidence is there of PCOMS improving treatment outcome and therapeutic relationship between clients and counsellors? (2) Has the use of PCOMS resulted in any unexpected outcomes for clients or treatment services? (3) How does PCOMS benefit different populations? Is it culturally appropriate for Chinese clients? If so, to what extent it helps Chinese clients. (4) How does PCOMS support counsellors in developing and demonstrating their skills and competencies?

What evidence is there of PCOMS improving treatment outcome and therapeutic relationship between clients and counsellors?

For this first question, I hypothesized that the routine track of clients' Outcome Rating Scale (ORS) and Session Rating Scale (SRS) scores would become significant evidence of predicting treatment outcomes and improving therapeutic alliance. Existing studies and statistics support my first hypothesis. In my literature review, Mikeal and Gillaspy et al. (2016) stated that therapists track client improvement or deterioration by collecting ongoing client feedback. It allows therapists to better tailor treatment in ways that meet clients' needs.

Psychotherapy outcome research has shown that a significant number of clients do not make progress as expected in treatment and, as a result, are at risk for deterioration and drop out (Lambert & Ogles, 2004). Using OQ-45, a similar client feedback system with PCOMS, Lambert (2013) reviewed nine controlled studies using feedback measures. His meta-analysis combined data from six well-designed clinical trials that compared TAU to feedback-assisted treatment in which the same therapist offered both conditions to over 4,000 clients. Results indicated that feedback to therapists and clients had a powerful effect over TAU with cases that were predicted to be treatment failures (20%-30% of clients). The deterioration rate was reduced by 50% (to 9%),

and positive outcomes increased from 22% in TAU to 38% in the feedback condition (Lambert, 2013). These figures replicated Lambert's (2010) meta-analysis finding that the number of psychotherapy clients who deteriorate can be cut in half using OQ-45 or PCOMS systems.

In PCOMS, research evidence has been supportive of the reliability and validity of both ORS and SRS (Minieri et al., 2015; Yates et al.,2016). A review of the ORS and SRS, referred to as "ultra-brief measures of alliance and outcome," concluded that the scales offer a feasible client response collection method as they address the time constraint barrier (Shaw & Murray, 2014). The PCOMS embraces two known predictors of ultimate treatment outcome. First, Clients who report little or no progress early on will likely show no improvement over the entire therapy course or end up on the dropout list. Second, a robust predictor of outcome solidly demonstrated by many studies is the therapeutic alliance. Clients who highly rate their partnership with their therapists are more apt to remain in therapy and benefit from it (Duncan & Sparks, 2015). To sum up, therapists use responses from the PCOMS scales to start a discussion with the client and then use PCOMS to evaluate client progress and the therapeutic relationship. The PCOMS graph of scores over time allows clients to visually see their progress and facilitate more in-depth topics on their progress.

In terms of empirical evidence, researchers utilizing the ORS and SRS consistently found that clients who gave feedback experienced numerous benefits in psychotherapy and a doubled overall effect size in their progress compared with clients who received treatment as usual (TAU) (Minieri et al., 2015). Researchers reviewed significant findings from several representative studies in individuals, couples, and group therapy. In individual therapy, Reese, Norsworthy et al. (2009) and Reese, Duncan et al. (2015) conducted two randomized clinical trials on PCOMS in a university counseling center and a training clinic focusing on whether PCOMS works with more

distressed and impoverished clients. Brattland et al. (2018) compared ROM with the treatment as usual (TAU) group in a mental health clinic. ROM group had 2.5 times more likely than TAU in outcome improvement. In couple therapy, two studies have been conducted on PCOMS, one in Norway (Anker, Duncan, & Sparks, 2009) and the other in the United States (Reese, Toland, Slone, & Norsworthy, 2010). In both studies, couples in the feedback condition had significantly better outcomes than the no-feedback team. Couples who provided feedback to their therapist were substantially less likely to separate or divorce six months after the study ended. In group therapy, two studies have evaluated the ORS (Schuman, Slone et al., 2015; Slone, Reese et al., 2015). In both studies, clients in the feedback conditions had better outcomes and were also more likely to have achieved clinically reliable change. Additionally, clients in the feedback conditions were less likely to terminate prematurely.

Has the use of PCOMS resulted in any unexpected outcomes for clients or treatment services?

For this second question, I hypothesized that there are no unexpected outcomes when using PCOMS. Despite considerable positive support of PCOMS in my literature review, four studies have found mixed or nonsignificant feedback effects. Murphy, Rashleigh, and Timulak (2012) found a non- significant advantage for using the ORS in total change and the number of clients reaching reliable growth. In cognitive-behavioral therapy, Janse, de Jong et al. (2016) found no advantage of PCOMS on the Symptom Checklist Revised-90, but clients in the feedback condition achieved change in significantly fewer sessions. Third, an investigation addressing PCOMS in emergency psychiatry found no differences in the ORS and the OQ. Last, in the eating disorder group psychotherapy (N =159), Davidsen et al. (2017) found no significant differences between PCOMS and TAU on attendance.

Using the ORS was a way for counsellors to identify those expectations and establish clear boundaries about what could be achieved in counselling. Additionally, ORS scores over time could be taken into consideration by counsellors to identify clients at risk of dropping out of counselling or who required extra support. When they saw that a client was not improving after several sessions or who consistently had low scores, this could prompt them to consider what was not working for that client. But a survey of participant therapists revealed that therapists did not discuss PCOMS feedback with clients and did not find it useful. Counsellors had mixed views on the usefulness of SRS data for developing and improving the therapeutic relationship with clients, and some counsellors not using the data at all (Bellringer et al., 2019). Adverse reactions to PCOMS from clients have also been reported, particularly by clients who did not understand the value of progress measures (those with mental health issues such as personality disorder or paranoia). Routine use has also led some clients to become bored with the steps, completing them as quickly as possible (Ionita et al., 2016).

How does PCOMS benefit different populations? Is it culturally appropriate for Chinese clients?

For the third question, I hypothesized that PCOMS benefits different populations. Although current empirical support is mostly from American and European White samples, PCOMS might not be culturally appropriate for Chinese clients, and it will be useful only to some extent. In my literature review, few studies have examined PCOMS and its recommended use for different ethnicities and cultures. Reese, Duncan, Bohanske, Owen, and Minami (2014) evaluated the effectiveness of psychotherapy services for individuals of lower socioeconomic backgrounds in the US, including Hispanic, African American, Native American, Asian American, and Euro-American, and no significant differences in outcomes were found for the different ethnic groups.

To follow up on cross-cultural competency study, Hayes, Owen et al. (2015) argued that although some psychotherapists produce better outcomes than others, their research in university clinic found that outcome for racial/ethnic minority (REM) and non-REM clients did not differ. Also, Reese, Duncan et al. (2017) evaluated outcome and readmission rate in an inpatient psychiatric facility in the US, and the study found that demographic variables had little impact on effectiveness. In the previous hypothesis question one, eight out of nine significant empirical supports of PCOMS effectiveness are from the US, and only one is from Norway. Some preliminary PCOMS studies have been conducted in Europe with White samples, such as the Netherlands, Denmark, and Spain (Sundet, 2012; Østergård et al., 2019; Partridge, Dykeman, 2019). In my review, I concluded that PCOMS benefits different people groups in North America and Europe, and the treatment outcome has no significant difference based on demographic variables.

Although the existing studies were evidence-based, I agreed with Manthei (2015) on his study implication that possible cultural and national differences in ORS and SRS scores across countries should be considered and noted. Manthei (2015) also pointed out that the ORS and SRS scales have been translated and used in different languages based on the assumption that the USA clinical cut-off scores are internationally applicable. For Chinese clients, none of PCOMS related studies were conducted solely with this people group in western countries. Only two RCTs studies investigated the feedback effect outside of the United States or Europe. First, Chow & Huixian (2015) examined the impact of ROM (Routine Outcome Monitoring) by using PCOMS in an Asian outpatient psychiatric hospital in Singapore (most are Chinese). The study result showed that the feedback group achieved more significant clinical improvements than the non-feedback group regarding the magnitude of change, reliable improvement, and reliable recovery rates. There was also a reduction of dropout rates after the first session and deterioration rates. Second, she et al.

(2018) had the first study to demonstrate the effects of improved outcomes and efficiency associated with a client feedback intervention in a Mandarin setting. This study examined the impact of a client feedback intervention, the PCOMS, in a college counseling center in Wuhan, China. Clients in the feedback condition demonstrated significantly more significant improvement than those in the TAU condition at posttreatment. Not-on-track (n = 60) clients also showed considerably more improvement at six times the rate of reliable change than the TAU condition. Although preliminary, this study suggested that the positive effects of improved outcomes and increased efficiency associated with systematic client feedback could also occur in a college counseling setting in China (She et al., 2018).

Two years later, Sun et al. (2020) had a secondary data analysis from She et al. (2018), it examined the alliance-outcome relation from the same sample. Results affirm the cross-cultural stability of the session-by-session reciprocal effects of the alliance-outcome model in a Chinese sample. Sun & Wu et al. (2020) suggested that the reciprocal influence model may be stable across cultures. However, I do not think Sun and Wu's suggestion is strongly supported since only several PCOMS studies were conducted outside North America. Three elements need to re-consider when using PCOMS in a Chinese setting. (1) Cross-cultural difference. Rooted in Confucianism, the Chinese are taught to respect authority/superior. Chinese clients often expect expert opinions or a directive counseling style. Also, implicit communication as a Chinese norm of "face-saving" in social touch indicates that therapists should make an effort to discern and attune to clients' unexpressed needs and wishes. We know that PCOMS is intended to be transparent and collaborative, so question around how to create collaboration without confusing the traditional hierarchy and resulting in no feedback effect needs to consider. (2) Translation equivalence. ORS and SRS have been translated from English to Chinese (She, Duncan et al., 2018; Sun, Wu et al.,

2020). Some research showed that no equivalent Chinese words are available for some commonly used English emotional terms such as "concern." The Chinese tend to use relatively few expressive words when talking about their relations. Therefore, translation accuracy and equivalence play a significant role when using outcome measures, like PCOMS, cross-culturally, and further research is much needed. (3) Therapist-client matching. Clients for whom cultural concerns were strongly related to their presenting problems preferred therapists who matched them in race/ethnicity and gender (Miserocchi, 2014). The therapist-client matching consideration does not apply to She, Duncan et al. (2018) and Sun, Wu et al. (2020) 's studies. Still, I imagine that this element is hugely considered in North America's multicultural therapeutic settings.

How does PCOMS support counsellors in developing and demonstrating their skills and competencies?

For the last question, I also hypothesized that PCOMS benefits counsellors in improving clients' outcomes and supervision. Studies support PCOMS in supervision and training that using client PCOMS data during clinical supervision may be a way to enhance therapist development. Lambert and Hawkins (2001) were the first to suggest that supervision could use client outcome data to discuss client progress and inform future treatment. Duncan (2016) clarified that what makes PCOMS-based supervision different from other methods is its emphasis on clients. I strongly agree with this idea that I have been practicing PCOMS-based supervision in my work. I know that it improves outcomes via identifying at-risk clients, then focuses on the supervisee and professional development using ORS data as an objective standard of effectiveness over time. However, only a few studies have investigated the outcomes of using client PCOMS data in clinical supervision (Bellringer et al., 2019).

Speaking to PCOMS in training, Minieri, Reese et al. (2015) outlined how PCOMS in psychotherapy and supervision can serve as a useful training tool that is a form of evidence-based practice (EBP) also promotes a socially just paradigm in psychotherapy. Miller, Duncan, Brown, Sorrell, and Chalk (2006) conducted the first study of PCOMS training from therapists' perspectives. One year after their PCOMS training, 99% of the therapists at this center continued to use feedback measures regularly with clients (Rousmaniere, Goodyear et al., 2017). In terms of therapist effect, Miller and his colleagues formed a Cycle of Excellence theory, and "deliberate practice" has been applying to many therapists.

Limitations

The advantages of PCOMS include the simplicity of the ORS and SRS scales and the minimal implementation time with clients. However, PCOMS still encounters resistance from both therapists and clients. The potential of PCOMS for reducing dropout rates with non-English speaking clients is an essential aspect of research.

Limitation of Usefulness

Manthei (2015) noted that since the ORS only measures general well-being, a disadvantage was that it could not be used to assess the particular problem for which counselling was sought. Similarly, Hafkenscheid et al. (2010) noted that the ORS does not measure "clinical risk factors such as suicide or alcohol or drug use" (p. 10). They concluded that outcome evaluations based on PCOMS " were far from comprehensive and did not contain multiple perspectives. Twenty-one researchers based in either Canada or the USA, and four were based in Australia, New Zealand, the United Kingdom, and India (Ionita et al., 2016). They raised dissatisfaction with the PCOMS measures, including skepticism about the usefulness and validity of measures that ask "vague questions to get at something as hard to pin down as well-being," and

concerns over variability in scores, which seem to reflect how the week might have been for the clients rather than their actual well-being.

The Concerns of Use

In the previous literature review, Sundet (2012) noted that while the therapists were optimistic about the scales' feasibility, they had concerns that the scales could disrupt therapy. One problem was the possibility that "the scales could become an occasion for deflecting attention and focus away from the central agenda of the therapy towards aspects of the scales" (p. 125). Sundet (2012) was also concerned about the ORS item on client social well-being, including work colleagues and friendships. Although Shaw and Murray (2014) noted the advantage of PCOMS in its simplicity and minimal implementation time, they also cautioned that improper use might result in two risks to therapy: (1) the scales are used in a mechanical way rather than as a clinical tool to encourage meaningful discussion of the relationship, monitoring change and tailoring treatment to suit each individual; (2) the therapist has power over a client if a client is forced, rather than invited, to complete the scales.

Clients' Negative Reaction

Although ORS and SRS's use has high client acceptance in most of the existing studies, Ionita's et al. (2016) analyzed clients' adverse reactions to PCOMS, and those clients did not understand the value of progress measures (those with mental health issues such as personality disorder or paranoia). Routine use has also led some clients to become bored with the steps, completing them as quickly as possible. In Hafkenscheid et al. (2010) study, they pointed out that the ORS and SRS limitations include reliance on self-assessments and lack of control for social desirability influences circumstances associated with power issues such as when a client has been referred for treatment by another agency. In such cases, clients may provide higher ORS scores to

show that everything is fine and hide their vulnerability or failure feelings. Besides, some clients found it embarrassing or difficult to rate the counsellor sitting in front of them because they did not want to offend the counsellor or felt pressured to give a high rating.

Cultural Adaptation

Duncan and Reese (2015) believe that PCOMS offers a culturally responsive process that can benefit clients of Color. In a broader view of the client feedback literature, current feedback researches have been predominantly conducted with non-Hispanic and White individuals (Minieri et al., 2015). PCOMS has been translated and used in the Netherlands (Hafkenscheid, Duncan and Miller, 2010; Janse et al., 2014), New Zealand (Bridgman, 2015), Norway (Sundet, 2012), Spain (Gimeno-Peón et al.,2019), and Denmark (Østergård, Randa & Hougaard, 2018). Some studies in Europe suggested that the average ORS and SRS scores were lower than samples from America. They reasoned that while this may reflect an overall lack of change in some European samples, it could also indicate cross-cultural differences. Therefore, the presented findings need to be interpreted with caution due to several limitations. First, all the instruments used were developed and validated in the United States. Although care was taken in the translation process, questions remain concerning the validity of the measures used in countries outside of the US (Duncan et al., 2012). Second, Sun et al. (2017) suggested that there were distinct differences between the Western and Eastern cultural norms in the actual process of building relationships. Third, Chinese therapists' training based on Western psychotherapy models may be incongruent with Chinese clients' perceptions of psychotherapy. This incongruence within the dyad can be a culturally-specific source of alliance strain or rupture.

Organizational Training

Sundet (2012) cautioned of the risks of using the ORS and SRS in an organizational context, as they are also "a technology with controlling and disciplining functions according to norms and standards set by the agency or health authorities" (p. 304). In other words, the client data may be used for therapist performance monitoring. It becomes an issue when scale scores are no longer therapeutic tools but tools for survival (therapists with low test scores can be fired) and reward (therapists with clients who score positively receive a bonus). A possible scenario is when therapists' economic and workplace well-being increasingly depends on the ORS and SRS scores. In open or subtle ways, it can lead therapists to influence clients to change scores in a direction that supports the organization. Also, there is some evidence to suggest that trainee therapy outcomes improve using client feedback (Reese et al., 2009). More evidence is needed to understand how this process specifically promotes trainee development and can enhance the supervisory process (Minieri et al., 2015).

Implications

Deliberate Practice

PCOMS is integrated within therapy, enabling ongoing assessment of treatment. It also serves as a tool for initiating meaningful conversations to lead to better outcomes and therapeutic alliance. As discussed previously, major current studies examined the PCOMS feedback effect, but few studies looked into the therapist effect when using PCOMS with a different population. In terms of therapist professional development, some researchers have noticed how PCOMS can benefit therapists and agencies in their counselling routine work and skills training, which Eriscsson (2009) calls it "deliberate practice." In 2015, Chow and associates published the first study on the impact of deliberate practice on therapist development. The research examined the relationship between the outcome and various practitioner variables, including demographics,

work practices, participation in professional development activities, beliefs regarding learning and growth as a therapist, and personal appraisals of therapeutic effectiveness (Rousmaniere, Goodyear et al., 2017). At the same time, Boswell, Kraus, Miller, and Lambert (2015) described the need for research to incorporate the deliberate practice of soliciting and incorporating negative feedback, especially in cases where the PCOMS is used. Therefore, I firmly believe that PCOMS brings efficacy in monitoring psychotherapy outcome and alliance, and sheds more light on skills training and clinician development.

Researchers have advocated the complimentary use of an audio-video recording of therapy sessions to aid the session's moment-by-moment focus. The recording enables both supervisor and supervisee to monitor the counselling process, thus providing a platform to review and guide the supervisee's work. Finally, not only can the supervisor provide guidance and consultation "one client at a time," but the supervisor can also help design specific training activities to improve well-defined areas of clinical skills "one therapist at a time" (Chow, 2014).

PCOMS Use in Local Agency

As more and more agencies and organizations adopted the feedback system by using PCOMS, more work around improving outcomes and helping the therapist grow is needed to be documented and examined. For example, Touchstone Family Association in BC Canada, an agency where I am working, has adopted PCOMS for around eight years. It serves people who speak English, Mandarin, and Punjab, including immigrants. Some counsellors from the agency had commented that non-White clients tended to give higher ratings than White clients. For some Asian clients, there appeared to be problems in understanding the scales' terminology, particularly the well-being aspects of the ORS. It may have contributed to the higher scores. Counsellors also suggested that some Chinese clients scored SRS highly due to respect for the "teacher" (counsellor).

Wan (2001) argued that a lack of equivalence could bring problems if minority members whose first language is not English use an English-language scale as they may lack the cognitive structure for the concept. As this Capstone has discussed, cross-cultural difference and translation equivalence need to be considered when using PCOMS with Asian/Chinese clients. To examine universality and cultural adaption of PCOMS in a multicultural counselling agency, such as Touchstone, is significant. As the above implicated, a fundamental requisite for accurate translation is the presence of equivalent terms in the new language. Furthermore, a suggested comparison of the ORS study on Asian and non-Asian counsellors can be made in Touchstone Family Association.

Conclusion

The PCOMS, routinely measuring outcome and the alliance with every client, ensures that neither issue is left to chance. It allows both transparency and true partnership with clients, keeping their perspectives on the centerpiece. Also, PCOMS serves as an early warning device that identifies clients who are not benefiting so that the client and the therapist can chart a different course. In turn, it encourages the counsellor to step outside of business as usual, do new things, and therefore continue to grow as a therapist. Finally, PCOMS helps clients focus on what needs to change outside of therapy and during the hour. (Duncan & Sparks, 2016). Self-report tests, such as ORS and SRS, have a firm reliance on language that can be problematic with translations and the originals administered to cultural group members whose first language is not English (Wan, 2001). Chinese clients and European clients evaluated in this Capstone may indicate cultural differences, and different wording with translation and different cut-off scores for the ORS or SRS would be more suitable. Therefore, translation accuracy and equivalence play a significant role

when using outcome measures, like PCOMS, cross-culturally, and further research is much needed.

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Appendix

Outcome Rating Scale (ORS)

Name _____Age (Yrs):____ Sex: M / F
Session # _____ Date: _____
Who is filling out this form? Please check one: Self_____ Other_____
If other, what is your relationship to this person? _____

Looking back over the last week, including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels. *If you are filling out this form for another person, please fill out according to how you think he or she is doing.*

Individually
(Personal well-being)

I----------I

Interpersonally
(Family, close relationships)

I----------I

Socially
(Work, school, friendships)

I----------I

Overall
(General sense of well-being)

I----------I

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Session Rating Scale (SRS V.3.0)

Name _____Age (Yrs):____ Sex: M / F
Session # _____ Date: _____
Who is filling out this form? Please check one: Self_____ Other_____
If other, what is your relationship to this person? _____

Please rate today's session by placing a mark on the line nearest to the description that best fits your experience.

Relationship

I did not feel heard, understood, and respected. I----------I I felt heard, understood, and respected.

Goals and Topics

We did *not* work on or talk about what I wanted to work on and talk about. I----------I We worked on and talked about what I wanted to work on and talk about.

Approach or Method

The therapist's approach is not a good fit for me. I----------I The therapist's approach is a good fit for me.

Overall

There was something missing in the session today. I----------I Overall, today's session was right for me.

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