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The Partners for Change Outcome Management System (PCOMS)

Revisiting the Client's Frame of Reference

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### Abstract

Despite overall psychotherapy efficacy (Lambert, 2013), many clients do not benefit (Reese, Duncan, Bohanske, Owen, & Minami, 2014), dropouts are a problem (Swift & Greenberg, 2012), and therapists vary significantly in success rates (Baldwin & Imel, 2013), are poor judges of negative outcomes (Chapman et al., 2012), and grossly overestimate their effectiveness (Walfish, McAlister, O'Donnell, & Lambert, 2012). Systematic client feedback offers one solution (Duncan, 2014). Several feedback systems have emerged (Castonguay, Barkham, Lutz, & McAleavey, 2013), but only two have randomized clinical trial support and are included in the Substance Abuse and Mental Health Administration's National Registry of Evidence based Programs and Practices: The Outcome Questionnaire-45.2 System (Lambert, 2010) and the Partners for Change Outcome Management System (PCOMS; Duncan, 2012). This article presents the current status of the Partners for Change Outcome Management System, the psychometrics of the PCOMS measures, its empirical support, and its clinical and training applications. Future directions and implications of PCOMS research, training, and practice are detailed. Finally, we propose that systematic feedback offers a way, via large scale data collection, to re-prioritize what matters to psychotherapy outcome, reclaim our empirically validated core values and identity, and change the conversation from a medical model dominated discourse to a more scientific, relational perspective.

## The Partners for Change Outcome Management System

## Revisiting the Client's Frame of Reference

*However beautiful the strategy, you should occasionally look at the results.*

Sir Winston Churchill

Despite overall psychotherapy efficacy (Lambert, 2013), many clients do not benefit (Reese, Duncan, Bohankse, Owen, & Minami, 2014), dropouts are a problem (Swift & Greenberg, 2012), and therapists vary significantly in success rates (Baldwin & Imel, 2013), are poor judges of negative outcomes (Chapman et al., 2012; Hannan et al., 2005), and grossly overestimate their effectiveness (Walfish, McAlister, O'Donnell, & Lambert, 2012). Systematic client feedback offers one solution (Duncan, 2014). It refers to the continuous monitoring of client perceptions of progress throughout therapy and a real-time comparison with an expected treatment response to gauge client progress and signal when change is not occurring as predicted. With this alert, clinicians and clients have an opportunity to shift focus, re-visit goals, or alter interventions before deterioration or dropout.

Several feedback systems have emerged (Castonguay, Barkham, Lutz, & McAleavey, 2013), but only two have randomized clinical trial (RCT) support and are included in the Substance Abuse and Mental Health Administration's (SAMHSA) National Registry of Evidence based Programs and Practices. First is the Outcome Questionnaire-45.2 System (OQ; Lambert, 2010). Michael Lambert is the pioneer of systematic feedback, evolving pre-post outcome measurement to a "real time" feedback process with a proven track record of improving outcomes. The OQ was designed to monitor client functioning at each session, the first measure to do so. Lambert and colleagues have convincingly established that measuring outcomes is not just for researchers anymore and belongs in everyday clinical practice.

The other systematic feedback intervention included in SAMHSA's National Registry is the Partners for Change Outcome Management System (PCOMS; Duncan, 2012). Emerging from clinical practice and designed with the front-line clinician in mind, PCOMS employs two, four item scales, one focusing on outcome (the Outcome Rating Scale; Miller, Duncan, Brown, Sparks, & Claud, 2003) and the other assessing the therapeutic alliance (the Session Rating Scale; Duncan et al., 2003). PCOMS directly involves clinicians and clients in an ongoing process of measuring and discussing both progress and the alliance, the first system to do so.

A meta-analytic review of six OQ System studies ( $N = 6,151$ ) revealed clients in the feedback condition had less than half the odds of experiencing deterioration and approximately 2.6 times higher odds of attaining reliable improvement than did those in treatment as usual (TAU) (Lambert & Shimokawa, 2011). The same review evaluated three PCOMS studies ( $N = 558$ ), and reported clients in the feedback group had 3.5 times higher odds of experiencing reliable change and less than half the chance of deterioration. This review makes a strong case for the use of systematic feedback.

There are many similarities between the two systems, and in fact, Lambert provided the inspiration for PCOMS and the OQ formed the basis of the PCOMS outcome measure, the Outcome Rating Sale (ORS). Most notably, both assess the client's response to service and feed that information back to the therapist (or to both client and clinician) to enhance the possibility of success via identification of clients at risk for a negative outcome. Both, as noted, are evidenced based practices and are a-theoretical and not diagnostically based; both systems have demonstrated significant improvements in outcomes regardless of therapist model or client diagnosis. Both have developed algorithms for expected treatment response based on extensive

databases and have electronic systems for data collection, analyses, and real time feedback. Both have continued research agendas and have enjoyed widespread implementation.

But important differences exist: Unlike the OQ and most outcome instruments, the ORS is not a list of symptoms or problems checked by clients on a Likert scale. Rather it is an instrument that is individualized with each client to represent his or her idiosyncratic experience and reasons for service. Clients report their distress on three domains (personal, family, social) and the clinical conversation evolves this general framework into a specific representation of the reason(s) for service. Beyond the differences in the outcome measure, by design, PCOMS is transparent in all aspects and intended to promote collaboration with clients in all decisions that affect their care. PCOMS is integrated into the ongoing psychotherapy process, creating space for discussion of not only progress but also the alliance (Duncan & Sparks, 2002).

The origins of the two systems are also different. While the OQ System arose from rigorous research and a desire to prevent treatment failures, PCOMS started from everyday clinical practice and a desire to privilege the client in the psychotherapy process. When feedback and the OQ were first introduced, the first author embraced it as a radical development—a methodology that routinely placed the client's construction of success at the center. It provided a way to operationalize what Duncan and Moynihan (1994), in an article in this journal entitled "Applying Outcome Research: Intentional Utilization of the Client's Frame Reference," called "client directed" clinical services. Applying the extensive empirical support for the common factors and especially the relationship/alliance, that article proposed a more intentional use of client "theories" to maximize common factor effects and client collaboration, and more devotion to client views of how therapy can address the reasons for service and what constitutes success.

Systematic feedback seemed not only a natural extension of this argument but, more

importantly, offered a way to make it happen—a structured process to honor the client's frame of reference while encouraging clinicians to routinely and transparently discuss outcome and the alliance. In essence, PCOMS arose from a desire to make manifest what mattered most in psychotherapy outcomes and a set of values about client privilege and egalitarian services. From that impetus, the ORS and the Session Rating Scale (SRS) were co-developed (Miller & Duncan, 2000; Miller, Duncan, & Johnson, 2002); the clinical process of PCOMS emerged from the first author's practice and supervision of graduate students (Duncan & Sparks, 2002).

PCOMS evolved from a clinical, relational, and value-driven starting place to an empirically validated methodology for improving outcomes and a viable quality improvement strategy. This article presents the current status of the Partners for Change Outcome Management System. First, the psychometrics of the PCOMS measures are discussed, its empirical support reviewed, and its clinical and training applications articulated. Future directions and implications of PCOMS research, training, and practice are detailed. Finally, we propose that systematic feedback offers a way to re-prioritize what matters to psychotherapy outcome, reclaim our empirically validated core values and identity, and change the conversation from a medical model dominated discourse to a more scientific, relational perspective.

### **PCOMS Psychometrics and Research**

**Outcome Rating Scale (ORS) and Session Rating Scale (SRS) Psychometrics.** A common concern is whether such brief measures can yield reliable and valid scores (Halstead, Youn, & Armijo, 2013). There is little doubt that information is lost when relying on only four items, but both measures hold up well to psychometric scrutiny. Multiple validation studies of the ORS (Bringhurst, Watson, Miller, & Duncan, 2006; Campbell & Hemsley, 2009; Reese, Toland, & Kodet, 2012; Miller et al., 2003) as well as efficacy studies (see below) have found that the ORS

generates reliable scores. Coefficient alphas have ranged from .87 to .91 in validation studies and from .82 (Reese, Norsworthy, & Rowlands, 2009; individual therapy) to .92 (Slone, Reese, Mathews-Duvall, & Kodet, 2015; group therapy) in clinical studies.

Research also suggests that the ORS generates valid scores as a measure of general distress. Three studies found evidence of concurrent validity for the ORS by comparing ORS scores to the OQ (Bringhurst et al., 2006; Campbell & Hemsley, 2009; Miller et al., 2003). Average bivariate correlations were .62 (range .53 - .74; Gillaspay & Murphy, 2011). A study that utilized an item response theory approach (Reese et al., 2012) found evidence for unidimensionality (i.e., construct validity) for the ORS. Two studies have also demonstrated that scores reflect real-world treatment outcomes. Anker, Duncan, and Sparks (2009) found that couples who had higher post treatment ORS scores were more likely to be together at 6-month follow-up. Schuman, Slone, Reese, and Duncan (2015) found that active-duty soldiers who had higher post ORS scores received higher behavioral ratings from their commander. Finally, an analysis of over 400,000 administrations of the ORS found the reliable change index (RCI) to be 6 points (Duncan, 2014) and confirmed an earlier study (Miller & Duncan, 2004) finding of a clinical cutoff (Jacobson & Truax, 1991) of 25. This RCI was recently corroborated by the Slone et al. (2015) data.

The SRS also has evidence of generating reliable and valid scores. Gillaspay and Murphy (2011) reported the average internal consistency of SRS scores across five studies equaled .92 (range .88 to .96). SRS scores also exhibit moderate evidence for concurrent validity with longer alliance measures;  $r = .48$  with the Helping Alliance Questionnaire-II (Duncan et al., 2003),  $r = .63$  with the Working Alliance Inventory (Campbell & Hemsley, 2009), and  $r = .65$  with the Working Alliance Inventory – Short Revised (Reese et al., 2013). The predictive validity of SRS

scores has been supported by two studies. Duncan et al. (2003) found a correlation of  $r = .29$  between early SRS scores and outcome, which is consistent with previous alliance-outcome research (Horvath, Del Re, Flückiger, & Symonds, 2011). More recently, Anker et al. (2010) reported third session SRS scores predicted outcome beyond early symptom change ( $d = 0.25$ ). Regarding the cutoff score for the SRS, a conservative estimate derived for clinical purposes with descriptive statistics (score at which the majority of clients are above) from the original analysis (Miller & Duncan, 2004) and updated from Anker et al. (2010) is 36.

A second concern raised regarding the validity of the measures is whether clients are unduly influenced by the PCOMS protocol of discussing the scores, particularly for the SRS. Reese et al. (2013) focused on social desirability and demand characteristics of completing the SRS in the presence of a clinician and did not find differences when clients were randomized to conditions where they completed the measure in front of their therapist, in private, or anonymously—clients completed the SRS similarly regardless of the demand characteristics.

**PCOMS Research.** There are currently five randomized clinical trials (RCT; see Table 1) that support the efficacy of PCOMS in individual (Reese, Norsworthy, et al., 2009), couple (Anker et al., 2009; Reese et al., 2010), and group (Schuman et al., 2015; Slone et al., 2015) therapy with adults, with overall effect sizes ranging from  $d = 0.28$  (group therapy) to 0.54 (individual therapy). Reese, Norsworthy, et al. (2009) conducted two studies where individual clients were randomized to a PCOMS or TAU condition. In both studies, clients in the feedback condition demonstrated roughly twice as much improvement on the ORS compared to TAU clients. In addition, more feedback clients achieved reliable change in significantly fewer sessions than TAU clients. Comparable ESs were found in each study.

Anker et al. (2009) randomized 205 couples to feedback or TAU. Compared to couples who received TAU, twice as much improvement was found on the ORS for feedback clients (8.27 vs. 3.11 points). Nearly four times as many couples in the feedback condition reached clinically significant change. These effects were maintained at 6-month follow-up and those in the feedback condition were significantly more likely to be together. Reese et al. (2010) replicated these findings in a second couple study ( $N = 92$ ) in terms of ORS gains (8.58 vs. 3.64 points) and clinically significant change. PCOMS clients also improved at a faster rate.

More recently, PCOMS research has extended to group psychotherapy with two RCTs. Schuman et al. (2015) evaluated an abbreviated PCOMS intervention with active Army soldiers in substance abuse treatment. Therapists in the abbreviated PCOMS format only received a graph based on ORS scores for each session indicating whether their group participants were progressing as expected. Therapists were not required to discuss the ORS nor did clients utilize the Group Session Rating Scale (GSRS; Duncan & Miller, 2007). Also, only the first five sessions of treatment were evaluated. Even with these limitations, participants in the PCOMS condition had larger pre-post treatment gains and attended more sessions compared to TAU clients. Clients in the PCOMS condition also received higher blinded ratings from their commanding officer. A second group psychotherapy study (Slone et al., 2015) conducted in a university counseling center found PCOMS clients had significantly larger pre-post treatment gains and higher rates of reliable and clinically significant change when compared to TAU clients. Therapists had access to both ORS and GSRS scores and were encouraged to discuss the measures with clients during group sessions.

Taken together, these five RCTs demonstrate a significant advantage of PCOMS over TAU. Clients in feedback conditions achieved more pre-post treatment gains, higher percentages

of reliable and clinically significant change, faster rates of change, and were less likely to drop out. These findings suggest that systematic feedback could offer a more cost effective and practical alternative as a quality improvement strategy compared to the transporting of evidence based treatments (Laska, Gurman, & Wampold, 2013).

To evaluate PCOMS as a quality improvement strategy, Reese et al. (2014) employed benchmarking (Minami et al., 2008) to investigate the post-treatment outcomes of 5,168 racially diverse, impoverished (all below the federal poverty level) adults who received therapy in a public behavioral health setting. The overall treatment effect size ( $d = 1.34$ ) for those with a depressive disorder ( $N = 1,589$ ) was comparable to treatment efficacy benchmarks from clinical trials of major depression ( $d = 0.89$ ). Treatment effect sizes for the entire sample ( $d = 0.71$ ) were also comparable to benchmarks derived from nine client feedback RCT studies ( $d = 0.56$ ) that used the OQ System and PCOMS (Lambert & Shimokawa, 2011).

### **PCOMS in Clinical Practice and Training**

**Clinical Practice.** The Partners for Change Outcome Management System provides a methodology to partner with clients to identify those who aren't responding and address the lack of progress in a proactive way that keeps clients engaged while new directions are collaboratively sought. PCOMS is a light-touch, checking-in process that usually takes about 5 minutes to administer, score, and integrate into the psychotherapy. Besides the brevity of its measures and therefore its feasibility for everyday use in the demanding schedules of clinicians, PCOMS is distinguished by its routine involvement of clients; client scores on the progress and alliance instruments are openly shared and discussed at each administration. Client views of progress serve as a basis for beginning conversations, and their assessments of the alliance mark an endpoint to the same. With this transparency, the measures provide a mutually understood

reference point for reasons for seeking service, progress, and engagement. PCOMS is used in mental health and substance abuse settings across the United States, Canada, and over 20 other countries, with over 1.5 million administrations in its database.

**The PCOMS Process.**<sup>1</sup> PCOMS and the session start with the Outcome Rating Scale (ORS; Miller et al., 2003). The ORS is a visual analog scale consisting of four 10 cm lines, corresponding to four domains (individual, interpersonal, social, and overall). Clients place a mark (or mouse click or touch) on each line to represent their perception of their functioning in each domain. Therapists use a 10 cm ruler (or available software) to sum the client's total score, with a maximum score of 40. Lower scores reflect more distress.

Introducing the ORS includes two points: 1) the ORS is a way to make sure that the client's voice remains central; and 2) the ORS will be used to track outcome in every session.

*I like to start with this brief form called the Outcome Rating Scale, which provides a snapshot of how you are doing right now. It serves as an anchor point so we can track your progress and make sure that you get what you came here to get, and if you're not, we can regroup and try something else. It's also a way to make sure that your perspective of how you are doing stays central. Would you mind doing it for me?*

The task after the score is totaled is to make sense of it with the final authority—the client. The “clinical cutoff” facilitates a shared understanding of the ORS and is often a step toward connecting client marks on the ORS to the reason for services.

*Therapist: What I do is I just measure this up, it's four 10 cm lines and it gives a score from 0 to 40 and I just pull out this ruler and add up the scores, and then I will tell you about what this says and you can tell me whether it is accurate or not...Okay, you scored*

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<sup>1</sup> The PCOMS family of instruments are free for individual use at [pcoms.com](http://pcoms.com) and free resources regarding PCOMS are available at [heartandsoulofchange.com](http://heartandsoulofchange.com)

*a 19.8. This scale, the Outcome Rating Scale has what's called a cutoff of 25, and people who score under 25 tend to be those who wind up talking to people like me, they're looking for something different in their lives. You scored about the average intake score of persons who enter therapy, so you're in the right place. And it's not hard to look at this and see pretty quickly that it's the family/close relationship area you are struggling with the most right now. Does that make sense?*

*Client: Yes, definitely.*

*Therapist: So what do you think would be the most useful thing for us to talk about?*

*Client: Well, I am in the middle of divorce and struggling with figuring this out...*

Clients most often mark the scale the lowest that they are there to talk about. The ORS brings an understanding of the client's experience to the opening minutes of a session.

The ORS is individually tailored by design, requiring the practitioner to ensure that the ORS represents both the client's experience and the reasons for service. At the moment clients connect the marks on the ORS with the situations that prompt their seeking help, the ORS becomes a meaningful measure of progress and a potent clinical tool—leading to the next question: “What do you think it will take to move your mark just one cm to the right; what needs to happen out there and in here?” With the same client as above:

*Therapist: If I am getting this right, you said that you are struggling with the divorce, specifically about why it happened and your part in it so you are looking to explore this and gain some insight into what perhaps was your contribution. You marked the Interpersonally Scale the lowest (Therapist picks up the ORS.) Does that mark represent this struggle and your longing for some clarity?*

*Client: Yes.*

*Therapist: So, if we are able to explore this situation and reach some insights that resonate with you, do you think that it would move that mark to the right?*

*Client: Yes, that is what I am hoping for and what I think will help me. I know I wasn't perfect in the relationship and I want to understand my part. I already know his part!*

The ORS sets the stage and focuses the work at hand.

The Session Rating Scale (SRS; Duncan et al., 2003), also a four item visual analog scale, covers the classic elements of the alliance (Bordin, 1979) and is given toward the end of a session. Similar to the ORS, each line on the SRS is 10 cm and can be scored manually or electronically. Use of the SRS encourages all client feedback, positive and negative, creating a safe space for clients to voice their honest opinions about their connection to their therapist and to psychotherapy. Introducing the SRS works best as a natural extension of the therapist's style:

*Let's take a minute and have you fill out the other form about our work together, the Session Rating Scale. It's kind of like taking the temperature of our session today. Was it too hot or too cold? Do I need to adjust the thermostat to make you feel more comfortable? The purpose is to make every possible effort to make our work together beneficial for you. If something is amiss, you would be doing me the best favor to let me know because then I can do something about it. Would you mind doing this for me?*

For clients scoring above the cutoff of 36, the therapist need only thank the client, inquire about what the client found particularly helpful, and invite the client to please inform the therapist if anything can improve the therapy. For clients scoring below 36, the conversation is similar but also attempts to explore what can be done to improve the therapy:

*Therapist: Thanks for doing that. Looks like it could have gone better for you today. That's exactly what this form is for. What could I have done differently?*

*Client: Well, it wasn't really bad or anything. Might just take some time.*

*Therapist: Okay. Was there something else I should have asked?*

*Client: No, it's just that I think it will take a while for me to trust that this is going to do any good. I don't know much about this therapy stuff. I have just been seeing the psychiatrist and taking the medications.*

*Therapist: Okay, that makes sense. Your marks on the "approach" and "something missing" aspects were a bit lower than the others. So, part of this is a time thing—so, if we are on the right track, your scores will likely go up?*

*Client: Yes. After we talk a bit more about what I can do about my damn ruminations.*

*Therapist: That makes perfect sense. When we get rolling next time more on some specifics, like the cognitive strategies we briefly discussed, that will likely help?*

*Client: Yes, I think so.*

The SRS provides a structure to address the alliance, allows an opportunity to fix any problems, and demonstrates that the therapist does more than give lip service to forming good relationships.

After the first session, PCOMS simply asks: are things better or not? ORS scores are used to engage the client in a discussion about progress, and more importantly, what should be done differently if there isn't any. When ORS scores increase, a crucial step to empower the change is to help clients see any gains as a consequence of their own efforts. Reliable and clinically significant change provide helpful metrics to gauge noted gains. When clients reach a plateau or what may be the maximum benefit they will derive from service, planning for continued recovery outside of therapy starts.

A more important discussion occurs when ORS scores are not increasing. The longer psychotherapy continues without measurable change, the greater the likelihood of dropout and/or

poor outcome. PCOMS is intended to stimulate both interested parties to reflect on the implications of continuing a process that is yielding little or no benefit. Although addressed in each meeting in which it is apparent no change is occurring, later sessions gain increasing significance and warrant additional action—what we have called *checkpoint conversations* and *last chance discussions* (Duncan & Sparks, 2002).

Checkpoint conversations are conducted at the third to sixth session and last-chance discussions are initiated in the sixth to ninth meeting. The trajectories observed in outpatient settings suggest that most clients who benefit usually show it in 3–6 sessions (Duncan, 2014); and if change is not noted by then, then the client is at a risk for a negative outcome. The same goes for sessions 6-9 except that the urgency is increased, hence the term “last chance.” Available web-based systems provide a more nuanced identification of clients at risk by comparing the client’s progress to the expected treatment response of clients with the same intake score. The progression of the conversation with clients who are not benefiting goes from talking about whether something different should be done, to identifying what can be done differently, to considering other treatment options including transferring the client to a different provider. The conversation begins:

*Okay, so things haven't changed since the last time we talked. How do you make sense of that? Should we be doing something different here, or should we continue on course steady as we go? If we are going to stay on the same course, how long should we go before getting worried? When will we know when to say “when?”*

PCOMS spotlights the lack of change, making it impossible to ignore, and often ignites both therapist and client into action—to consider other treatment options and evaluate whether

another provider may offer a different set of options and perhaps a better match with client preferences, culture, and frame of reference.

**Implementing PCOMS.** PCOMS increases in value exponentially when it extends beyond the client therapist dyad to proactively address those who are not responding at an organizational level. Successful implementation of PCOMS requires data collection, data integrity, and the timely dissemination of data to the supervisory process. The method of collecting PCOMS data can range from Excel, to an electronic health records' existing data collection, graphing, and analysis functions, to commercial web based services (BetterOutcomesNow.com and MyOutcomes.com). All enable therapists and supervisors to review first and most recent ORS scores and number of sessions to identify clients who are not benefitting. The percentage of clients who achieve reliable or clinically significant change (RCSC) or reach the expected treatment response (ETR) provides an easily understood metric of effectiveness and a way to track therapist development and agency improvement over time.

A four step supervisory process (Duncan & Reese, in press) focuses first on ORS identified clients at risk and then on therapist development. This supervision is a departure from convention because rather than the supervisee choosing who is discussed, clients choose themselves by virtue of their ORS scores and lack of change. Each at risk client is discussed and options are developed to present to clients, including the possibility of consultation with or referral to another counselor or service. This is perhaps the most traditional role of supervision but here there are objective criteria to identify at risk clients as well as subsequent ORS scores to see if the changes recommended by the supervisory process have been helpful to the client.

This process is intended to be the antidote for blaming clients or therapists. Not all clients benefit from services. No clinician serves all clients. If we accept that, we can move on to the

more productive conversation of what needs to happen next to enable the consumer to benefit.

*Supervisor: Looks like we are still struggling with this client...he's been in therapy for 9 sessions and still not realized any benefit. What does the client say at this point?*

*Supervisee: He is pretty much at a loss and doesn't have any other ideas. He came in after trying antidepressants, and not liking how he felt when he took them. Now, he feels pretty hopeless after all we have done, which goes with his presentation of feeling very depressed.*

*Supervisor: What do you think about the alliance? Is the client engaged and working?*

*Supervisee: Definitely. SRS scores are good and I know that he trusts me.*

*Supervisor: Great. Please summarize for me what you have done so far to try to turn things around. We have discussed this client before and have tried a couple of different plans.*

*Supervisee: Well, I started working with him from a more cognitive perspective but after discussion with the client, that didn't seem a very good fit. A couple of supervisory meetings ago, we developed a plan to more specifically identify what the factors he thought were contributing to his depression based on his lowest score on the ORS being on the interpersonal domain. We did that and I thought we were on the right track but the client didn't want to bring in his partner. And our discussions about the malaise in his relationship haven't resulted in any changes.*

*Supervisor: Do you think that you have gone as far as you can go with this client?*

*Supervisee: No, I think I can try some more things.*

*Supervisor: We all have limits and have a finite number of things we can do and ways we can be with the people we work with.*

*Supervisee: Yes, I guess I am at a loss.*

*Supervisor: Okay, let's look at what we can do from our side. A colleague could sit with*

*you to interview your client, or perhaps a team, or I could sit with you and see if the “new blood” might generate new leads. And I know you have discussed with the client that another therapist may be a better fit, so it is also time to revisit that discussion as a real possibility.*

PCOMS supervision also encourages therapist reflection about their development and a plan of improvement via an open discussion of effectiveness (percent reaching ETR or RSCS):

*Supervisor: So based on your last 30 closed clients in your Excel file, your average change is 4.5 and your RCSC rate is 37.6%.*

*Supervisee: That doesn't look so good.*

*Supervisor: Remember the studies of therapist effectiveness we have discussed so you are not that far off the pace. Also keep in mind that you are likely to see a bump in effectiveness because you are now identifying clients who are not benefiting.*

*Supervisee: That's true. So you think the next 30 will be better?*

*Supervisor: I do. What else do you think might enhance your outcomes?*

*Supervisee: Well, I don't think I am that great at forming alliances with clients who present more affectively. I am better at cognitive stuff.*

*Supervisor: Okay, let's look at ways that you might get better at that.*

From the frank discussion of effectiveness and the supervisee's ideas about improvement, a plan is formed. The plan is then implemented and modified if outcomes are not improving.

**PCOMS in Clinical Training.** As suggested by the above example, the benefits of client feedback may extend to clinician development and training (Sparks, Kisler, Adams, & Blumen, 2011; Worthen & Lambert, 2007). Receiving normative-based feedback regarding effectiveness not only permits adjustments session-to-session but also highlights therapist strengths and weaknesses. Two studies (Grossl, Reese, Norsworthy, & Hopkins, 2014; Reese, Usher, et al.,

2009) have demonstrated that, at the least, the supervisory process was not negatively affected by using PCOMS in supervision, with the Grossl et al. study indicating that trainees who discussed their PCOMS data in supervision were more satisfied than trainees who received supervision as usual. Moreover, Reese, Usher, et al. found that trainees who used PCOMS had more improvement across an academic semester than trainees who did not use systematic feedback.

Using client feedback data in clinical training balances the developmental needs of the trainee and the welfare of the client, facilitates how supervisory feedback is given and received (Worthen & Lambert, 2007), and provides both a formative and summative means to evaluate the transport of clinical skills from the classroom to the therapy room (Sparks et al., 2011). Bringing the client's "voice" to supervision helps ensure that client progress, or lack thereof, is not overlooked. Although the purpose of supervision is to promote clinician professional development and client welfare, supervision typically is tilted toward the supervisee's needs (Worthen & Lambert, 2007). This happens, in part, because the supervisee is present and helps shape how his or her caseload is perceived. This is problematic because therapists generally overestimate their abilities (Walfish et al., 2012) and their client's progress (Chapman et al., 2012; Hatfield, McCullough, Plucinski, & Krieger, 2010).

Inclusion of PCOMS data in training may enable supervisors to provide better feedback, including challenging feedback, as illustrated in the above supervision example. Supervisors often do not offer critical feedback to trainees, and when such feedback is given it is often not specific (Harris, 1994; Hoffman Hill, Holmes, & Fritas, 2005). Reese, Usher, et al. (2009) anecdotally found that supervisors indicated more comfort with providing critical feedback when PCOMS data was included because it seemed more objective.

Finally, PCOMS data evaluates if training in the classroom or elsewhere is translating into actual practice (Sparks et al., 2011). The American Psychological Association's (APA) Task Force on the Assessment of Competence (APA, 2006a) recommended that clinicians continuously measure educational and professional outcomes throughout their careers to evaluate competence. Although care needs to be taken not to treat outcome/alliance data in an evaluative matter (e.g., academic grades, merit raises, or continued employment being contingent upon certain scores), the nature of continuous data can facilitate formative evaluation rather than waiting on summative semester or annual evaluations. Supervisors and supervisees can be more responsive to needs of the client, and in turn, the professional goals of the supervisee.

### **Implications of PCOMS for the Future of Psychotherapy Training, Research, and Practice**

**Rationales for PCOMS.** There are six rationales for PCOMS. First, PCOMS is supported by five RCTS demonstrating that client outcome and alliance feedback significantly improves outcomes in individual, couple, and group therapy. Second, PCOMS has demonstrated that it is a viable quality improvement strategy in real world settings and may be more cost effective and feasible than transporting evidence based treatments for specific disorders (Reese et al., 2014). Third, PCOMS reduces dropouts, cancelations, no shows, and length of stay (Bohanske & Franczak, 2010), provides objective information about clinician effectiveness, and reduces therapist variability (Anker et al., 2009). Fourth, PCOMS incorporates two known predictors of ultimate treatment outcome, early change (Howard et al., 1986; Baldwin, Berkeljon, Atkins, Olsen, & Nielsen, 2009), and the therapeutic alliance (Horvath et al., 2011). Monitoring change and the alliance provides a tangible way to identify non-responding clients and relationship problems before clients drop out or achieve a negative outcome. Fifth, PCOMS directly applies the research about what really matters in therapeutic change, the common factors (Duncan,

Miller, Wampold, & Hubble, 2010). Collaborative monitoring of outcome engages the most potent source of change, clients (Bohart & Tallman, 2010), thereby heightening hope for improvement, and tailors services to client preferences thereby maximizing the alliance and participation (Duncan, 2014). Finally, a sixth rationale started long before the psychometrics, RCTs, or benchmarking studies.

**A Larger Rationale.** Despite well-intentioned efforts, the infrastructure of psychotherapy (paperwork, procedures, and professional language) can reify non-contextualized descriptions of client problems and silence their views, goals, and preferences. When services are provided without intimate connection to those receiving them and to their response and preferences, clients can become cardboard cutouts, the object of our professional deliberations. PCOMS can help overcome these pitfalls.

Routinely requesting, documenting, and responding to client feedback has the potential to transform power relations by privileging client beliefs and goals over potentially culturally biased and insensitive practices. Valuing clients as credible sources of their own experiences of progress and relationship allows consumers to teach us how we can be the most effective with them and reverse the hierarchy of expert delivered services. PCOMS provides a ready-made structure for collaboration with consumers and promotes a more egalitarian psychotherapeutic process. It ensures therapy's match with a client's preferred future via monitoring progress on the ORS. And it provides a way to calibrate therapy to a client's goals and preferred way of achieving goals via monitoring the alliance with the SRS. Thus, PCOMS promotes the values of social justice by privileging consumer voice over manuals and theories enabling idiosyncratic and culturally responsive practice with diverse clientele.

Outside the therapy dyad, client-generated data help overcome inequities built into everyday service delivery by redefining whose voice counts. Without the data, client views do not stand a chance to be part of the real record—that is, critical information that guides decisions or evaluates eventual outcomes at larger programmatic or organizational levels. The data, as concrete representations of client perspectives, offer a direct way to describe benefit at clinician and agency levels as well as keep client voice primary to how services are delivered and funded.

PCOMS supports a social justice paradigm via consciousness raising and ongoing self-examination (Goodman et al., 2004). The items on the ORS help to contextualize a client's presenting problem beyond diagnostic categories, running counter to practices that pathologize clients of color and other historically marginalized groups at higher rates (Sue & Sue, 2008). Putting client reasons for service in context can also promote consciousness raising for both client and therapist, and help identify forms of oppression and marginalization that may contribute to distress. Moreover, given that self-awareness is critical to cultural competence (Pieterse, Lee, Ritmeester, & Collins, 2013), 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.

**Future Research.** Client feedback research is an encouraging but still emerging literature. The Heart and Soul of Change Project<sup>2</sup> has several studies in process, including: the ORS in primary care, PCOMS in integrated care, and benchmark outcomes in acute inpatient care and with youth in an outpatient public behavioral health setting. We also offer three research areas we believe

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<sup>2</sup> The Heart and Soul of Change Project (<https://heartandsoulofchange.com>) is a training and research consortium that conducted all of the RCTs regarding PCOMS. We are committed to consumer privilege, a relational model of psychotherapy, outcome accountability, and demonstrating that social justice makes empirical sense.

are critical to better understanding how, when, where, and who benefits from PCOMS or from client feedback more generally. First, future study needs to evaluate if client feedback is beneficial for clients of color given that current RCTs have largely consisted of White samples. Client feedback systems were developed primarily to reduce premature termination, and clients of color have generally had higher rates (Kearney, Draper, & Baron, 2005). Although the Reese et al. (2014) benchmarking study found no differences based on race/ethnicity, more research is needed to specifically evaluate PCOMS with traditionally disenfranchised clients. We believe that PCOMS offers a culturally responsive process that can benefit clients of color but research is needed to evaluate this contention. The process of proactively seeking input from clients may be of particular import for clients from marginalized and historically oppressed groups.

Research is also needed to evaluate PCOMS with youth, another potentially marginalized group given the inherent power differential with children and adolescents. We know of only one controlled study that evaluated feedback with youth (Bickman, Kelley, Breda, de Andrade, & Riemer, 2011), which found limited but promising results. PCOMS may help give youth a “voice” and ensure their perspective is taken seriously. Preliminary evidence for PCOMS was found in a cohort study with children (ages 7-11) (Cooper, Stewart, Sparks, & Bunting, 2013).

Given the proliferation of feedback systems, another important research question is whether their differences alter outcomes. For example, is the inclusion of an alliance measure discussed every session important to treatment outcomes? If so, what is the unique contribution of this process? PCOMS measures and discusses the alliance every session, but the OQ System does not employ an alliance measure unless there is no progress. Similarly, feedback systems have been categorized as either normative or communicative (Halstead et al., 2013). Is one better than the other regarding outcomes? The OQ System and PCOMS are both normative

systems that utilize nomothetic measures. Both require reliable and valid measures and rely substantially on normative data. On the other hand, communicative feedback systems are primarily designed to facilitate conversations about client concerns and are viewed more as clinical tools. Psychometric properties are considered secondary. PCOMS is also communicative. We would argue, therefore, that normative and communicative approaches be considered on a continuum rather than categorical. An interesting question emerges regarding where on the continuum better outcomes are generated. Empirically differentiating what elements are critical to outcome will help both our understanding and practice of feedback.

**And Beyond.** Putting research tools in the hands of everyday clinicians is revolutionary and could perhaps fuel a radical reconsideration of the medical model of psychotherapy, the dominant paradigm. While the medical model, simplified to diagnosis plus prescriptive treatment equals cure or symptom amelioration, is a valid approach to physical problems, its assumptions do not hold up in psychotherapy. It reduces clients to diagnoses and therapists to treatment technologies while failing to acknowledge the importance of relationship or the idiosyncrasies of the human condition (Duncan & Reese, 2012). This medical view of therapy is empirically vacuous because diagnosis yields little that is helpful and model/technique accounts for so little of outcome variance, while the client and the therapist—and their relationship—account for so much more.

The late George Albee (2000) suggested that psychology made a Faustian deal with the medical model at the Boulder conference in 1949, where psychology's bible of training was developed with a fatal flaw, "...the uncritical acceptance of the medical model, the organic explanation of mental disorders, with psychiatric hegemony, medical concepts, and language" (p. 247). Since then, in spite of a substantial empirical unmasking of its assumptions (e.g., Elkins, in

press), the medical model and its primary foot soldier, diagnosis, has remained a fixed part of graduate training, a prominent feature of evidence based treatments, and a prerequisite for research funding and service reimbursement—all of which engenders an illusion of scientific aura and clinical utility that far overreaches its empirical basis. Psychotherapy, in fact, is a relational, not medical endeavor (Duncan, 2014), one that is wholly dependent on the participants and the quality of their interpersonal connection.

Large-scale collection of outcome data could help reevaluate funding parameters and the medical model assumptions that support them. As more evidence shows the lack of relationship between diagnoses, evidence based treatments, length of stay, and improvement, the real predictors of progress may come to light (again) and a different set of assumptions, like those of partnership, recovery, and individually tailored treatment, can be implemented. This would allow us to escape the medicalization of our identity and offer a different legacy to our students. The story of clients as passive patients with illnesses who require treatment from technical experts administering powerful interventions, hopefully, will soon go out of print. Instead, a more empirically based account of psychotherapy in proportion to the amount of variance attributed to the different common factors (including our vast resources of models and techniques), and a way to describe the consumers of our services in ways other than their diseases, disorders, deficits, disabilities, or dysfunctions—will soon arise. Our identity as psychologists and psychotherapists would reflect the interpersonal and relational nature of the work, as well as the consumer's perspective of the benefit and fit of the services.

These are thorny topics and with the movement to integrated care, they are likely to become increasingly vital. Our collaboration with and respect for medical professionals is essential, as is retention of our own separate identity. Our task is to be a valued member of a

collaborative team, respecting the medical model while keeping our relational model and the factors that account for behavioral change central to our work. We have an empirically grounded argument to help medical professionals learn about the power of relationship and the importance of engaging patients in any treatments administered. Research is increasingly showing that the alliance between physician and patient is a predictor of medical outcomes (Kelley, Kraft-Todd, Schapira, Kossowsky, & Riess, 2014). Combined with the overwhelming amount of data supporting the same in psychotherapy, perhaps it is time for the medical model to be embedded in our relational model rather than vice versa.

The next generation of psychologists can be proud of what psychotherapy has to offer and not accept second-class status. Unfortunately, the use of psychotherapy alone and in combination with medication has decreased while the use of medications alone has increased (Olfson & Marcus, 2010). Psychotherapy, despite robust evidence of effectiveness and the unfavorable risk benefit profile of psychotropics (Sparks et al., 2010) appears to have been demoted to a lower tiered way to help clients. Good marketing trumps bad data every time—but this need not be the case if we decide to act on the science that supports a relational perspective and reclaim our identity. Our identity is embedded in the fact that psychotherapy is an evidence-based, stand alone, effective treatment for the wide variety of concerns, problems, and issues—both catastrophic and everyday—that human beings encounter in life.

### **Conclusions**

*If a man [sic] will kick a fact out of the window, when he comes back he finds it again in the chimney corner.*

Ralph Waldo Emerson

PCOMS offers a way to operationalize what Duncan and Moynihan (1994) called a

“client directed” process in psychotherapy. In reviewing that nearly 22 year-old article, it is apparent that the more things change, the more they stay the same. That article used the even then abundant research literature regarding the dodo verdict, the common factors, and especially the relationship, to propose a more intentional focus on the client’s frame of reference about what constitutes success in therapy as well as what makes a good alliance. Comparing the available knowledge then and what is even more robust now (see Wampold & Imel, 2015), the conclusions from the research are largely more of the same.

PCOMS also offers a seemingly contradictory way to be evidence based across clients while tailoring services to the individual’s needs, preferences, and culture. While common factors research point to those elements influential to positive outcomes and evidence based treatments provide guidance for intervention selection, the specifics of psychotherapy can only emerge from the client’s response to what we deliver—the client’s feedback regarding progress and the alliance. The APA Task Force on Evidence Based Practice in Psychology states:

The application of research evidence to a given patient (sic) always involves probabilistic inferences. Therefore, ongoing monitoring of patient progress and adjustment of treatment as needed are essential (2006, p. 280).

PCOMS embraces the uncertainty inherent in “probabilistic inferences” about what will be helpful for a given individual, and provides a way to therapeutically manage it.

The science of psychotherapy continues to guide clinical practice toward a more relational perspective of psychotherapy (Rogers, 1957) and to a more common factors understanding of therapeutic change (Rosenzweig, 1936). Perhaps it is time to not kick these facts out of the window, and instead, reclaim our core empirical values and relational identity, and deliver evidence based practice one client at a time.

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Table 1

*Randomized Clinical Trials for PCOMS*

Reference	<i>N</i>	Format	Setting	Pre ORS <i>M</i> ( <i>SD</i> )	Post ORS <i>M</i> ( <i>SD</i> )	<i>D</i>
Reese et al. (2009) Study 1	74	Individual	University Counseling Center	18.59 (7.60)	31.28 (6.63)	0.54
Reese et al. (2009) Study 2	74	Individual	University Training Clinic	18.68 (10.39)	29.51 (9.58)	0.49
Anker et al. (2009)	410	Couple	Community Mental Health	18.08 (7.85)	26.35 (10.02)	0.50
Reese et al. (2010)	92	Couple	University Training Clinic	23.34 (9.15)	31.92 (7.15)	0.54
Schuman et al. (2014)	2	Group	Military Treatment Clinic	22.42 (10.01)	28.28 (9.46)	0.28
Slone et al. (2015)	84	Group	University Counseling Center	23.47 (7.86)	30.87 (6.49)	0.41

*Note.* PCOMS = Partners for Change Outcome Management System. Pre-post ORS mean scores are for PCOMS feedback conditions; *d* = between group effect sizes.