The role of Routine Outcomes Evaluation in developing reflexivity in clinical practice

Introduction

Routine outcomes evaluation (ROE) involves using standardised questionnaires within the ordinary course to therapy, usually after each session, for evaluation of therapeutic progress. Within the UK, large-scale ROE is used within IAPT to evaluate the effectiveness of psychotherapy for moderate anxiety and depression. Outcomes are published and used to create benchmarks for psychological therapies within the NHS (Glover, Webb, Evison, & Northoff, 2010. ,Gyani, Shafran, Layard, & Clark, 2013)(Clark et al., 2009). Some organisations within the voluntary and statutory sectors have adopted this methodology, primarily to demonstrate their effectiveness and gain funding, but ROE has not been adopted by the therapeutic community in general. Routine outcomes evaluation in psychotherapy is one of the areas where the gap between the therapeutic community, researchers and policy makers is at its widest. The majority of psychotherapists only use it if required by their employer, and don't see it as relevant or clinically useful. This puts the therapeutic community at a disadvantage and places them outside of the decision-making process about the provision of psychotherapy and counselling services.Reflection from both psychotherapists and researchers is needed to bridge this gap.

As a psychotherapist and a researcher, I have insight into some of the issues on both sides. On the one hand, a body of research indicates that the reflection we already use in practice has limits, particularly in evaluating our own effectiveness. On the other, ROE , when used mechanistically, also doesn't have the capacity to develop practice. The aim of this paper is to present some of my thinking about gaps in practice and research in this area, raise questions and make suggestions about a way forward.

Why do we need to develop methods of feedback and evaluation in psychotherapy?

Importance of feedback in psychotherapy, as in any professional activity, seems to be self-evident. We need to recognise the impact of our interventions and adapt our work to help clients achieve their aims. Therapists have long been alert to this, and various methods of reflecting on the psychotherapy processes and outcomes have become embedded into psychotherapy training and practice. Students are observed in their practice sessions during training. Many of them audio-record their sessions, and all have supervision and personal psychotherapy. This suggests that we already have multiple methods and skills in assessing the effectiveness of our practice and our abilities.

Unfortunately, research suggests that this is not as effective as we might think. Psychotherapists seem to suffer from a self-assessment bias similar to that found in other professions. Research by (Walfish, McAlister, O'Donnell, & Lambert, 2012) found that most of their participants rated their skills as above average in comparison to their peers. The therapists thought that only 3.66% of their clients deteriorated during therapy, and 47.7% of the sample said that none of their clients deteriorated. Similar results were found in other studies (Lambert & Shimokawa, 2011; Lambert et al., 2002).

These evaluations seem to be very inaccurate, when compared to actual psychotherapy outcomes. Psychotherapy outcomes research shows that, on average, only about 40% of clients achieve clinically significant change, and up to 20% deteriorate, across the different therapeutic settings.

In addition to that, a review of literature on alliance ruptures shows that they are far more frequent than therapists' identify, or clients disclose (Muran, Safran, & Eubanks-Carter, 2010; Safran, Muran, & Eubanks-Carter, 2011).

The literature on premature endings in therapy also shows that they are common in both public services (Pekarik & Finney-Owen, 1987), and in private practice (Mueller & Pekarik, 2000). Therapists' skills in building and repairing the relationship have the impact on the drop-out rates(Roos & Werbart, 2013). The question that arises is how can we realistically assess alliance ruptures and outcomes in our own practice?

Research like this suggests that we need to find a way of reviewing or supplementing our ways of reflecting on our practice, even when dealing with something as familiar as identifying alliance ruptures, our own skills assessment, and our clients' need for different ways of working. As a profession, we might have moved too far away from formal evaluation methods, that could have a role in this process.

What are the difficulties in using ROE?

(Holmqvist, Philips, & Barkham, 2013) address some of the tensions of using ROE in psychotherapy. I have frequently heard from students and colleagues that some of the outcome measures are not well suited to the practice of psychotherapy. Instead of aiding therapy, they are solely based on the medical model and seem to suit a political purpose, rather than support therapy. For example, the focus on anxiety and depression does not reflect a clinical reality where clients present with several coexisting issues. Psychotherapy formulation is far more helpful in developing treatment plans, and therapeutic theory is of far more help in working with clients than routine outcome measures (ROM).

ROE usually takes place in time-limited settings. However, long-term, or open-ended therapy, which usually take place in private practice do not have ROE protocols or measures suited to this type of work. For example, most of the commonly used measures rely on calculations of the clinical cut-off scores and are not particularly useful once clients have moved below the clinical range of symptoms. In my experience in long terms psychotherapy, that usually happens within the first six months to a year of therapy, when the more in-depth work usually starts.

Over the years of teaching students to use routine outcome measures (ROM) within the research clinic, I am aware of unease about using questionnaires and 'forms' , as if this format somehow did not suit the culture psychotherapy practice. This unease was amplified by fears of being assessed and 'measured'.

Bridging the gap by developing reflexivity in ROE

An approach to developing ROE needs to start from a reflection on what we might gain from it for the benefit of developing work with individual clients and using creativity to integrate it into the therapeutic process. The following are just some of the suggestions, used at Metanoia research clinic.

Developing clients' engagement and openness

In some psychotherapy settings, routine outcome measures are only used for evaluation of the service. Therapists do not see the clients' responses and are unable to use them in any way. There is an argument that this gives clients more freedom to provide feedback, but it not particularly helpful

to the therapeutic process. Instead of that, routine outcome measures could support engagement in self-reflection between the sessions. Completing a questionnaire once a week between the sessions, creates a structure that could assist reflection. They also give an opportunity for feedback to the therapist, without seeming too personal or rude, which is a concern for many clients. In this way, ROM could help to identify ruptures and attend to the working alliance. Finally, being able to have a conversation with a client about therapy, what works and what doesn't, has a role in building the therapeutic relationship and engaging clients in their own therapy. Openness about negotiating the aims of therapy and ways of working has been an integral part of humanistic therapies, such as transactional analysis (Sills, 1997) and has been more recently highlighted as a 'meta-therapeutic' dialogue within a pluralistic approach by (Cooper & McLeod, 2011).

Integration of measures into the therapeutic process

Questionnaires are frequently seen as alien to the therapeutic process. This is particularly the case for psychotherapists, in contrast to the clients. The formal wording, and structure of questionnaires seem to mark them out as something different to other personal material clients bring into sessions. However, some of that formality and consistency might also support the therapeutic process. For example, it would not be particularly useful to spend time each session in reviewing all aspects of clients' well-being, from their sleeping patterns to how often they felt despairing. Instead of that, both clients and therapists tend to choose whatever is a figural theme for them on the day. However, the information given by clients in ROMs could be significant for the therapeutic process and provide feedback to therapists. It could give indications that the client is at risk, becoming more distressed or deteriorating. Clients could communicate it regularly and quickly, without the need to to engage in prolonged and detailed enquiries each session. Of course, not all distress indicates deterioration and integrating the information into the therapeutic dialogue needs to be flexible and individual to each client. For example, therapists at Metanoia research clinic usually start by taking a bit of time to scan through the questionnaires the clients have brought into the session, ask them if they wanted to focus on anything from them, and also reflect on what they might have noticed, such as areas of risk, feedback on the therapeutic relationship, etc. Used in that way, questionnaires become an additional reflective tool and could be adapted to suit different clients and therapeutic styles.

Choosing measures that suit psychotherapy practice

Most commonly used measures in the UK focus on recognisable clinical disorders such as depression,PHQ-9 (Kroenke, Spitzer, & Williams, 2001) and anxiety GAD-7 (Spitzer, Kroenke, Williams, & Lowe, 2006). Measures of global distress such as CORE-OM (Barkham et al., 2001), helpful aspects of therapy (Elliott, 1993) and therapeutic relationship (Bordin, 1979; Tracey & Kokotovic, 1989) could be more suitable outside of the health settings. Many other measures that focus on interpersonal styles, attachment, compassion, etc. are available. They are easily accessible and many are free of charge.

Training of therapists and supervisors

For ROE to become common and integrated into therapeutic practice, it needs to be also integrated into psychotherapy training and supervision, alongside other reflective methods. Integration into training could support the change in the culture of psychotherapy. This could involve moving beyond the false dichotomy between subjectivity and objectivity and embracing a wider range of complexity of human expression. This might also mean that as individuals we might also need to embrace our

fallibility more fully and realise limits to our ability to know what is going on for our clients, or even within the process of psychotherapy.

Development of research

ROE in long-term psychotherapy

Current methods of ROE are poorly suited to long-term psychotherapy. Giving sessional measures to clients after the first year of psychotherapy, in my experience, makes it repetitive and needlessly mechanistic. It would be helpful to consider ways in which ROE could support the long-term therapeutic process. Using measures at regular intervals might be able to provide a history of the process that therapists and clients could use. For example, for clients who experience periods of emotional instability, ROM could help in developing ability for mentalization by remembering times when they felt very distressed and times when they were not.

Developing new questionnaires

There is a need to develop and test measures and methods lead by the therapeutic need; that psychotherapists would find truly useful. This suggests a need to conduct more research and engage therapists who work in private practice, as they are fast becoming the only providers of long-term psychotherapy.

Conclusion

Practice-based research in its quantitative, formal format of ROE presents a challenge to the therapeutic community. Is this something we could embrace and make our own? What can we learn from it? My view is that as a relational psychotherapist I would like to open up a wide range of discourse with my clients, including the sources that do not traditionally stem from psychotherapy. ROE could give us an opportunity to develop our reflexivity and responsiveness, as well as contribute to the body of practice-based research.

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