ICCE | The International Center for Clinical Excellence

Making Sense of Negative Research Results about Feedback Informed Treatment (FIT):

Worksheet and Evidence-based Guide

Over the last decade, multiple studies have been published questioning both how, and if, FIT has an impact on the outcome of mental health care.

The key to understanding negative results is seeing them as integral part of advancing understanding. Said another way, such studies should inspire reflection and refinement rather than blanket rejection of theories and practices.

In the material that follows, three sets of studies reporting negative results about FIT are presented. The worksheet takes the reader through a series of steps aimed at understanding the implications of these studies.

Set #1:

Mikeal et al. (2016)

Briefly, Mikeal and colleagues compared the typical FIT protocol -- ORS administered at the outset of each session and SRS at the end -- to therapies using just one or the other measure. Known as "dismantling," this type of study is specifically designed to test the contribution made by the different components comprising an approach. Importantly, the researchers found that using one or the combination of FIT measures (ORS & SRS) resulted in similar outcomes.

Before reading further, make a list of the implications of Mikeal et al. (2016) for FIT theory and practice. For example, when asked, readers often conclude:

- *FIT is not an empirically supported practice*
- *The therapist can pick and choose if, when, and what to measure*
- *The ORS and SRS are not valid measures of important factors in effective psychotherapy*
- *The effectiveness of FIT is not due to measurement*

Take a moment to reflect. What other implications might there be?

Next, consider Mikeal et al.'s (2016) results in the context of other FIT-related findings:

- Brown and Cazauvieilh (2019) found the more time a therapist spent consulting the data generated by routinely administering outcome and alliance measures, the greater their growth in their effectiveness over time.

- de Jong et al. (2012) found the impact of FIT varied by therapist, with the clients of those who were open and willing to use the feedback making progress more quickly.

- Brattland et al. (2019) found that the strength of the therapeutic relationship improved more over the course of care when clinicians used the Outcome and Session Rating Scales (ORS & SRS) compared to when they did not. Critically, such improvements resulted in better outcomes for clients, ultimately accounting for nearly a quarter of the effect of FIT.

- Brattland et al. (2019) also found therapists, "significantly differed in the influence of … [FIT] on the alliance, in the influence of the alliance on outcomes, and the residual direct effect of [FIT] … posttreatment" (p. 10). Consistent with other studies, such findings indicate routine measurement can be used to identify a clinician's "growth edge" — what, where, and with whom — they might improve their ability to relate to and help the diverse clients met in daily work."

In light of these findings, take time to make a *new* list of the implications of Mikeal et al. (2016) for FIT theory and practice. Hints can be found at the end of this document if needed. However, as the purpose of this worksheet is to deepen understanding of how research works, it's best to struggle than give in to the temptation to know the "answer."

In the meantime, the principle to follow when encountering anomalous research results is:

Principle #1: Consider the results in the context of other research findings.

(Of course, putting this principle into practice requires both awareness of and access to the broader FIT research. A summary of the growing body of studies can be found on the I.C.C.E. website at: https://centerforclinicalexcellence.com/fit-publications1/)

Set #2:

van Oenen et al. (2016), Rise et al. (2016), Davidsen et al. (2017), Pejtersen et al. (2018) & de Jong et al. (2019)

Beginning in 2016, studies began appearing in the literature variously showing FIT did not improve outcome, retention, or treatment length. These include:

- Van Oenen et al. (2016) found that FIT did not help and was actually associated with less improvement compared to treatment-as-usual, in people with acute and severe psychosocial or psychiatric problems referred in the middle of a crisis.

- In a study conducted at a mental health hospital, Rise et al. (2016) found that therapists using FIT achieved no better results in terms of mental health symptoms or patient activation than another group of practitioners providing treatment-as-usual.

- Davidsen et al. (2017) found that FIT neither increased attendance nor improved outcomes for outpatients in group psychotherapy for eating disorders.

- In a study conducted over a 9-month period, Pejtersen et al. (2022) found therapists using FIT achieved no better results in terms of well-being, reasons for terminating, length of treatment, housing stability, or employment status than another group of practitioners providing treatment-as-usual.

- de Jong et al. (2019) found that symptom severity of autistic children treated by therapists using FIT was no better post treatment than other practitioners providing treatment-as-usual.

Before reading further, make a list of the implications of studies 2 – 6 for FIT theory and practice. For example, when asked, some readers conclude:

- *FIT is not applicable/helpful in certain settings*
- *FIT is not applicable and may be harmful for clients with certain diagnoses*
- *FIT works best for clients with relatively minor problems*

Take a moment to reflect. What other implications might there be?

Next, recall, in attempting to understand the implications of these studies for FIT theory and practice, first apply Principle #1: "When encountering anomalous research results, it is helpful to consider them in the context of other research findings." To wit:

- In a study conducted at a crisis call center, Miller et al. (2006) involving 75 therapists and 6,424 clients, found providing formal, ongoing, norm-based feedback to therapists regarding clients' experience of the alliance and progress in treatment resulted in significant improvements in both client retention and outcome.

- In a hospital based mental health clinic, Brattland et al. (2018) found clients of therapists using FIT were 2.5 times more likely to improve than when the same therapists were providing treatment-as usual (care without feedback). However, the improvement in outcomes was not significant until the fourth year of implementation.

- Bovendeerd et al. (2021) found FIT improved outcomes by 25% compared to treatment-as-usual in a sample of mild to moderately impaired clients treated at 4 different treatment centers, with the researchers citing "stage of implementation" as critical to successful evaluation of impact.

- Østergård et al. (2018) reported an average of 4 and modal number of 1 hour of training in FIT for therapists participating in studies included in their systematic review and meta-analysis which concluded FIT had "small overall effect."

Now, take time to reflect on and revise your list of implications of studies 2 - 6 in light of these additional research results. Do not consult the list of hints at the end of this document at this point.

In the meantime, a second principle to follow when encountering anomalous research results is:

Principle #2: Design is destiny or "What actually was assessed in the study?"

To fully understand the results of any particular study, it is essential to move beyond the summary conclusions and consider the research design. The reason is that how researchers conduct their study has a profound, and often determinative impact on the results they obtain. Therefore, when reviewing a study with anomalous results, an important consideration is, "What actually was assessed in the study?"

With this question in mind, consider the nature of the research designs employed in the studies included in set 3:

- The studies by van Oenen et al. (2016), Rise et al. (2016) and Pejtersen et al. (2018) were of short duration (< 1 year). For example, Pejtersen et al. (2018) lasted only 9 months, with therapists having between 11 and 15 cases in the FIT condition and only 50% of clients having a second score (>50%).

- van Oenen et al. (2016), Rise et al. (2016) and Pejtersen et al. (2018) compared an active "treatment condition" (FIT) to "treatment as usual." As such, they did not control for a variety of confounding factors, most importantly the therapist. Recall, Brattland et al. (2018) used therapists as their own controls, finding clients of therapists using FIT were 2.5 times more likely to improve than when the same therapists were providing treatment-as usual (care without feedback).

- In the study by Davidsen et al. (2017) on group therapy for eating disorders, "therapists … did not use feedback as intended, that is, to individualize the treatment by adjusting or altering treatment length or actions according to client feedback" (p. 491). Indeed, when critical feedback was provided by the clients via the measures, the standardization of services took precedence, resulting in therapists routinely responding, "the type of treatment, it's length and activities, is non-negotiable."

- While the de Jong et al. (2019) study on the use FIT in psychological care with autistic children found no impact on symptom severity, quality of life improved dramatically among parents and children, fostering both a positive view of the child and treatment expectations.

- In the study conducted in an emergency psychiatric setting, Van Oenen et al. (2016) trained participating therapists to "discuss the SRS score and encourage patients to express any comments and concerns about the session by making suggestions about how to improve collaboration and therefore address potential breaches in the alliance. Therapists were given the discretion to decide how to interpret and best integrate scores during the course of the treatment" (pp. 2-3).

Now, take time to reflect on and revise your list of implications of studies 2 - 6 in light of these additional research results. Ask, regardless of what the researcher concludes, ask "What actually was assessed in the study?" As before, hints can be found at the end of this document if needed.

Set #3

Østergård et al. (2018) & Pejtersen et al. (2020)

Østergård et al. (2018) conducted a meta-analysis of 18 studies, reporting a small overall effect of using the PCOMS in counseling, but not psychiatric settings.

Pejtersen et al. (2020) conducted a meta-analysis and reported no evidence that FIT had an effect on the number of sessions attended by clients or that FIT improved the well-being of clients.

Before reading further, make a list of the implications of Østergård et al. (2018) and Pejtersen et al. (2020) for FIT theory and practice. For example, when asked, readers often conclude:

- *FIT is not applicable/helpful in certain settings*
- *FIT does not improve the efficiency of mental health care*
- *If FIT helps at all, it's best for clients with relatively minor problems*

Take a moment to reflect. What other implications might there be?

Next, apply Principle #1: "When encountering anomalous research results, it is helpful to consider them in the context of other research findings." To wit:

- Tam & Ronan (2017) conducted a meta-analysis of 12 studies of FIT in services directed at adolescents, finding the collection and application of continuous feedback throughout the course of care led to improved outcomes (e.g., symptom severity, level of functioning and/or goal attainment).

- Lambert et al. (2018) conducted a meta-analysis of 24 studies finding in two-thirds, FIT assisted psychotherapy was superior to treatment-as-usual offered by the same practitioners. With small to moderate effect sizes, studies showed feedback practices reduced deterioration rates and nearly doubled clinically significant/reliable change rates in clients who were predicted to have a poor outcome.

Continuing with principle #2 (Design is destiny or "What actually was assessed in the study?"), it will come as no surprise that the results of meta-analyses depend on the studies included.

With this in mind, consider the following study:

- de Jong et al. (2021) conducted the most comprehensive meta-analysis to date (58 studies), including both randomized and non-randomized trails and assessing the impact of a host of moderating variables (e.g., study and feedback characteristics) on outcome reported. Progress feedback reduced dropout rates (20%) symptoms for both on and off-track cases. No effects were found for treatment duration or and the percentage of deteriorated cases at the end of treatment. Studies providing training and using algorithm driven feedback (i.e., treatment response trajectories) had higher effect sizes.

Reflect on what considerations are important when reviewing a meta-analysis of FIT given de Jong et al (2021) and the research design details of studies 2 - 6 reviewed on page 5. Hints can be found at the end of this document if needed.

References

Bovendeerd et al. (2021). Enhancing the effect of psychotherapy through systematic client feedback in outpatient mental healthcare: A cluster randomized trial. *Psychotherapy Research*, *32*(6). https://doi.org/10.1080/10503307.2021.2015637

Brattland et al. (2018). The effect of routine outcome monitoring (ROM) on therapy outcomes in the course of an implementation process: A randomized clinical trial. *Journal of Counseling Psychology, 65*, 641-652.

Brattland et al. (2019). Does the working alliance mediate the effect of routine outcome monitoring and alliance feedback on psychotherapy outcomes? A secondary analysis from a randomized clinical trial. *Journal of Counseling Psychology, 66*(2), 234-246. https://doi: 10.1037/cou0000320

Brown et al., (2019). Clinician engagement in feedback informed care and patient outcomes. *Society for the Advancement of Psychotherapy Newsletter*. https://societyforpsychotherapy.org/clinician-engagement-in-feedback-informed-care-and-patient-outcomes/

Davidsen et al. (2017). Feedback in group psychotherapy for eating disorders: A randomized clinical trial. Journal of Consulting and Clinical Psychology, 85(5), 484–494. https://doi.org/10.1037/ccp0000173

de Jong, K. et al. (2012). Understanding the differential impact of outcome monitoring: therapist variables that moderate feedback effects in a randomized clinical trial. *Psychotherapy Research, 22*(4), 464-474. https://doi: 10.1080/10503307.2012.673023

de Jong, K. et al. (2021). Using progress feedback to improve outcomes and reduce drop-out, treatment duration, and deterioration: A multilevel meta-analysis. Clinical Psychology Review, 85. https://doi.org/10.1016/j.cpr.2021.102002

de Jong, R. (2019). The effect of patients' feeback on treatment outcome in a child and adolescent psychiatric sample: A randomized controlled trial. *European Child and Adolescent Psychiatry, 28*(6), 819-834. https://doi: 10.1007/s00787-018-1247-4

Lambert et al. (2018). Collecting and delivering progress feedback: A meta-analysis of routine outcome monitoring. Psychotherapy, 55(4), 520–537. https://doi.org/10.1037/pst0000167

Mikael, C., Gillaspy, J.A., Scoles, M.T. & Murphy, J.J. (2016). A dismantling study of the Partners for Change Outcome Management System. *Journal of Counseling Psychology*, *63*(6), 704-709.

Miller, S. et al. (2007). Supershrinks: Learning from the field's most effective practitioners. The Psychotherapy Networker, 31(6), 26-35, 56.

Owen, J. et al. (2016). The working alliance in treatment of military adolescents. *Journal of Consulting and Clinical Psychology*, *84*(3), 200-210.

Østergård et al. (2018). The effects of using the Partners for Change Outcome Management System as feedback tool in psychotherapy – A systematic review and meta-analysis. Psychotherapy Research, 30(2).

Pejtersen et al. (2022). Routine outcome monitoring in social service: A cluster randomized controlled trial. *Nordic Social Work Research.* https://doi.org/10.1080/2156857X.2022.2055626

Pejtersen et al. (2020). Feedback-informed treatment: A systematic review and meta-analysis of the partners for change outcome management system. *Journal of Counseling Psychology, 67*(6), 723-735. https://doi.org/10.1037/cou0000420

Rise et al. (2016). The long term effect on mental health symptoms and patient activation of using patient feedback scales in mental health outpatient treatment: A randomized trial. *Patient Education and Counseling, 99*(1), 164-168. https://doi.org/ 10.1016/j.pec.2015.07.016

Tam et al. (2017). The application of a feedback-informed approach in psychological service with youth: Systematic review and meta-analysis. *Clinical Psychology Review,* 55, 41-55. https://doi.org/10.1016/j.cpr.2017.04.005.

van Oenen et al. (2016). Feedback-informed treatment in emergency psychiatry: A randomized controlled trial. *BMC Psychiatry*, *16*, 110. https://doi.org/10.1186/s12888-016-0811-z

Hints:

Mikeal et al. (2016)

- FIT is not about measurement. It is a structured way of attending to the client and therapeutic relationship.
- The impact of soliciting client feedback regarding progress and the relationship depends on the person who is asking.
- If they are open and receptive, FIT helps therapists as much as it does their clients.

van Oenen et al. (2016), Rise et al. (2016), Davidsen et al. (2017), Pejtersen et al. (2018) & de Jong et al. (2019)

- FIT is not a treatment method but an organizing principle of agency and practice culture.
- FIT is not about administering the ORS and SRS. It's about actively using client feedback to guide and adjust treatment services.
- Therapists differ significantly in the influence of FIT on the alliance.
- Feedback is not synonymous with clients expressing concerns or making suggestions about what to change or improve. In certain contexts/situations (e.g., crisis), more direction open-ended exploration of poor outcome and relationship scores may undermine confidence in the therapist and exacerbate client feelings of hopelessness.
- Successful implementation of FIT requires several years of ongoing training and support and, in agency settings, an accompanying change of organizational culture.
- Different results may have more to do with differences in how studies are conducted than in the effectiveness of FIT.

Østergård et al. (2018), Pejtersen et al. (2020)

- The results of meta-analysis are influenced by which studies are included
- Meta-analyses of studies in which FIT was not fully implemented (e.g., little to no training, gathering but not acting on client feedback) produce negative, null or conflicting results.
- FIT likely has a small to moderate impact on outcome, retention and drop out that is highly dependent on the openness of clinicians to feedback and how well FIT is integrated into agency culture and practice.