How does Feedback-Informed Treatment fit with Solution-Focused Brief Therapy?

The "common factors"

In 1936, researcher Saul Rosenweig argued that factors common to different therapy models have a greater importance to client outcome than the model itself. He used the term "the Dodo bird effect" as a sideways reference to *Alice in Wonderland* (After a race in which it had not been clear how the winner would be judged, the Dodo bird proclaimed, "Everybody has won and all must have prizes.").

In 1992, researcher Michael Lambert estimated that "extratherapeutic" factors having nothing to do with formal therapeutic work account for roughly 40% of therapeutic progress, that therapeutic relationship factors ("the alliance") account for roughly 30%, client expectation or mindset and what is known as "the placebo effect" account for roughly 15%, and techniques unique to specific therapy models account for roughly 15%. These studies sparked a new wave of interest and engagement in research on common factors.

It is worth noting that Lambert is quite clear that the figures are his 'educated guess' and are not based on research, before or since, however, people have continued to quote the numbers as if they had been verified. Wampold's more recent work (2015) gives more accurate figures based on real studies, not guesswork.

Wampold proposes a "contextual model" and suggests that there are three common pathways that contribute to therapeutic change: a) the "real" therapist-client relationship, b) the creation of expectations and c) the enactment of health-promoting actions. There is a great emphasis on the centrality of the therapeutic relationship.

Feedback-Informed Treatment

In the 1990s and early 2000s, Scott Miller, along with Mark Hubble and Barry Duncan, wrote a great deal about "what works" in psychotherapy, focusing on "the common factors" that contribute to therapy success rather than on any particular model or approach. This culminated in their 1999 book, *The heart and soul of change: What works in therapy*, which championed the importance of "the common factors" in therapy success, including the therapeutic alliance. Previously, Scott Miller had been a key member of staff at the Brief Family Therapy Center in Milwaukee, Steve de Shazer and Insoo Kim Berg's therapy centre, where the Solution-Focused approach was developed and Scott Miller was an author of a number of Solution-Focused publications (including the book that is still a foundational text on Solution-Focused therapy with problem drinking). Interestingly, Miller and his colleagues wrote a book that argued that Solution Focused Brief Therapy was an approach that was most likely to promote the common factors. Scott Miller then went on to develop Feedback Informed Treatment, an approach that seeks constant feedback from the client about the therapeutic alliance and about the outcome of the therapeutic process.

Feedback-Informed Treatment uses the ORS (Outcome Rating Scale) to obtain feedback from the client about the therapeutic outcome (is therapy making a difference?) and the SRS (Session Rating Scale) to obtain feedback about the client's experience of the session (did the session promote/strengthen the therapeutic alliance?). Of course, I agree that both these questions are crucial.

What's better?

My problem is this … ultimately, what matters is what's better next session, when the client returns, not what did the client think of the session at the end of this session? Change happens "out there" in the client's world, not "in here" in the therapy session. I have certainly had clients who, if I'd asked them at the end of the first session, would have said that the session was not particularly helpful. However, they come back to the next session and lots of things are better.

Steve de Shazer thought that the single most important question we ask is, "What's better?". I think this is more important than "How did the client rate the (last) session?".

So, I think the conversation that follows the question, "What's (been) better?" is probably more useful than the ORS. Harry Korman (psychiatrist, Sweden) comments that the ORS does the same thing as the "What's better?" question.

I'm not sure that a client can judge, at the end of a session, whether or not the session has been useful. They have to wait and see if anything changes in order to answer the question. Of course, "What's better?" is probably more helpful than some version of, "Is our therapy being useful?, because we can never really know whether our therapy is responsible for any improvement. However, I can see that the SRS might be a useful way of finding out from the client whether anything in the therapy is detrimental to the therapeutic alliance.

Other Solution-Focused practitioners' experience

I asked a number of Solution-Focused practitioners about their experience of Feedback Informed Treatment.

* * * * *

Kidge Burns (Speech and Language Therapist, UK)

For a number of years, I was involved in implementing ORS/SRS within my department in the National Health Service in the UK. As Speech and Language Therapists, we don't have a good history of recording outcomes, which is quite an issue when people ask us to show evidence of improved communication. In my opinion, in all the time I worked as a Speech and Language Therapist (about 26 years), I never found outcome measures that focused on the impact of change so effectively as ORS. I no longer work as a Speech and Language Therapist, but continue to operate as a Solution-Focused practitioner and trainer.

In my book *Focus on Solutions*, I provide a transcript where 'John' is given the ORS form to fill out at the beginning of a session. He is delighted to notice change after a three month interval and says, "I didn't recall what they [ORS] were the last time I came here, but I just put down honestly how I was feeling today and it just ended up being quite high".

For John, the ORS enabled him to monitor how he might progress in personal well-being ('individually') separately from 'interpersonally', 'socially', and 'overall' (the other three parameters of ORS). Of course, they are interconnected, but he was able to notice improvement in himself in small areas before being able to think about bigger steps that he wanted to take regarding friends and socially. He wrote feedback to the NHS Trust (wonderful promo for our department and SFBT!) saying, "I think everybody in my situation should use SFBT. If I knew someone who had a stutter, I would highly recommend that they come here. It's about trying to get information out that there is a new way that we do speech therapy - maybe a lot of people out there could be able to access it".

I am well aware that change over time and between sessions cannot be easily attributed to what is happening only within therapy. But, as a tool that looks at areas of life functioning known to change as a result of therapeutic intervention and which fits in well with a more client-centred rather than a diagnosis-centred agenda, I think ORS was the best tool we had.

By the way I also liked SRS, particularly when it enabled the client to say if they weren't happy with something. Once, when I asked how we could improve on one of the parameters, I was told by the client that he thought the therapy room was in a mess and that bothered him. He was absolutely right about the mess and it was sorted!

* * * * *

Chris Iveson (therapist, Brief, London, UK)

We did have Scott Miller at BRIEF several times so were very familiar with the scales. All his case examples were of longer term therapies so it was hard to see a fit.

Nevertheless, I did try. Unfortunately, I couldn't find a way to use the SRS that did not seem to intrude on the client. Maybe because many of our clients then were 'sent' to us and so just wanted to get away as soon as possible!

I rarely see a client more than three times and often don't know what happens afterwards, so I can't for sure say how effective my work is but I assume it's about the same as it was when we ran our outcome research programme over 20 years between 1990 and 2010 (ish). If we are working under the assumption that our first session might well be the last, how do we make sense to the client of introducing a tool seemingly designed for longer-term therapy.

* * * * *

Eric Albert (Relationship counsellor, Maryland, USA)

I have used the SRS in hundreds of in-person sessions, and I used the ORS in a large number of sessions initially before giving up on it because I couldn't find an effective way to integrate it with my approach.

I agree that the SRS is much more useful if you typically do more than one session with clients. Still, even with single-session therapy, I could see its use in getting feedback, over time, about how a therapist could change their approach to better fit a higher percentage of clients.

With (an expectation of) multiple-session therapy, I think the SRS can be most helpful in catching clients who might not come back to a second session. I remember several times when I was shocked at a client's (low) rating, and it enabled me to immediately check in with them and address their concerns (which often involved me apologizing for doing something unskillful, or just generally not recognizing what they were looking for). I think most of the clients wouldn't have come back, so there wouldn't have been an opportunity for me to be a better fit.

I also found the SRS useful for many clients who might have come back anyway, but who would have been too bashful to share important information about their dissatisfaction with how I was running sessions. This was because, at least in the first session, clients almost never have any idea of what a "good" rating looks like, so unhappy clients give what they felt was "above average" but which I knew was, based on norms, low. This allowed me to address things that might never have come up. (By the second or third session, most clients could guess what I was looking for, and might adjust so I wouldn't ask, but the first session information was gold).

* * * * *

John Murphy (Psychologist, Arkansas, USA)

Chris, great point about the relevance of the ORS and SRS for single sessions as both measures (and the PCOMS system and other formal feedback systems as a whole – the OQ, etc.) were based on an assumption of 2 or more sessions, and the idea that the feedback can guide therapist/service adjustments for the next session. The end-of-session SRS feedback (even in single sessions) can be discussed in ways that acknowledge the client's contributions to the usefulness of the session (a very SF idea), and I've heard several practitioners say that the ORS helps clients focus on a hoped-for outcome from the work. On the other hand, both instruments introduce therapist-initiated language into the mix (not a very SF idea that speaks to Chris's point about not intruding on the client), even though the "explanation" preceding their use is client-centred ("... to make sure your voice in and experience of the work is front centre ... another very SF idea). And then there's the research piece involving several large RCT studies in which therapists were instructed to use the measures with half their clients and not the other half while doing everything else just as they typically do. . . with results of many such studies showing better outcomes for clients in the formal feedback groups.

Art Gillaspy and I have a chapter in the Franklin et al. book, *SFBT Handbook of Evidence-Based Practice* discussing the use of the ORS and SRS in SFBT. The chapter is called “Incorporating Outcome and Session Rating Scales in Solution-Focused Brief Therapy”. We emphasise the compatibility between core themes of FIT measures and SFBT (centralising clients, giving them a voice and choice in their care, requesting their feedback via scaling), and discuss logistical challenges and suggestions about how to incorporate the measures into SFBT work.

Formal scaling via FIT: (a) gives clients a formal, significant voice in their care; (b) gives practitioners a systematic way to monitor client perceptions of progress and alliance; and (c) encourages practitioners to use client feedback data as a source of continuing professional development and skill building in the areas of facilitating client participation and other useful counselling skills. The collaborative, client-directed philosophy of privileging clients’ input and experience throughout the helping process is central to FIT *and* Solution-Focused work.

Re. your comment, "it ultimately doesn't matter what the client thought of the session - what matters is what's better next time" ... yes, "what's better next time" is what we're aiming for in the work and your comment makes sense to me *as long as* "what the client thought of the session" does not impede "what's better next time" (a lot of research says it does).

* * * * *

Flavio Cannistra (Psychologist, Italy)

I have used FIT for many years and I think it's very useful, even with SFBT. I can share some clinical examples:

A) I used SFBT with an adolescent. She was quite responsive, answering all my SF questions and being engaged in the solution talk. We had a good session, in my opinion. But when I gave her SRS she put a not-very-high score in SRS (around a 7 - consider that a good score is 9 or 10). I asked her what we can do to improve that and she said she wanted a more confrontative session, wanted to listen to my opinions and feedback about what she said. In other words (I know that what I'm about to say will not be liked by many) she wanted "an expert". That was very useful to me. The next session I used SFBT again but sometimes I told her: "May I give you my feedback about that?", of course giving particular attention to not colonize her, to not give

my ideas but simply to give feedback in terms of "It seems that ... What do you think?", proposing without imposing.

B) A colleague, psychologist, came and I use SFBT very straight (Best Hopes, MQ, Present Scale, Future Scale, Conclusion, Noticing). The SRS's scale for the method was 8. I asked him if he wanted something different and he said: "I think it just takes time". I can't tell why, maybe it's just experience, but I guess if with that kind of *person* I should try something different. I did SFBT again during the second session but that time I was more "flexible" with some comments and metaphors - just to paraphrase what he said. That time SRS' subscale was 10 and he spontaneously says: "I prefer this less rigid way" to use the method.

C) Another colleague, Rogersian, came. I started with SFBT but I "feel" that it was better to let her express, even to talk about the past - I DON'T explore the past, simply she wanted to talk about something and I let her do so. At the end of the session, the whole SRS was 32: It should be 36 to say that it's good. I asked her if there was something to improve and she said she wanted a more structured method and to talk about the present day. I say that that's what I usually do but, in that session, I felt she needed to be left to tell what she wanted. She replied: "You know what? You did right. Actually, if you had followed a more structured method in *this* session I probably feel it too rigid and constraining". In the second session, I did "more ordinary" SFBT, and the SRS was 36.

D) This is a case in which I have NOT used SRS. A man told me he was depressed. I worked with him for 3 sessions. I did SFBT very carefully and he was responsive, describing the preferred future, the details about the present scale, what he would see one step ahead etc. Between the third and the fourth session he sent me a message: "I don't want any session anymore. I want some homework and not just being told to "notice what is better". I guess a CBT is better for me". It was sad to me because I've also a strategic therapy background and I could fit easily his request continuing in doing SFBT

F) Another case without SRS. A woman came with her sister. We did SFBT in the first session and during the second she reported a big improvement, she also smiled and she continued to be engaged in the solution talk - as she did in the first session. Between the second and the third she sent me a message: "I don't want to continue anymore. You just ask me questions and never give me answers - which is what I want". Note: in my opinion in this case - as the adolescent's one - that doesn't mean we have to give an "answer" like "Your life is this and that" or "This IS what you have to do". Often, it's simply to change some little thing in the method like providing some feedback or giving some metaphor. Actually, it is often what is done in many SFBT methods (like BRIEF's) when, at the end, you come to the conclusion saying: "So you said that ...". Doing this during the session is often liked by those who asked me to give some feedback. But also, sometimes, it's also to share ideas. Like: "Oh you said this and that ... Maybe I'm wrong, but it seems you don't like that, do you? You haven't said that, so maybe it's just my impression. I just would like to share with you and know what you think".

* * * * *

Harry Korman (Psychiatrist, Sweden)

What I have found useful with low scores on the SRS is that me apologizing for the bad fit and asking what I need to think about next time. It increases my chances of seeing a client once more. I guess you know that the client's evaluation of the "alliance" (as measured on the SRS) is correlated both with outcome and client not showing up to the next appointment. The therapist's evaluation of the alliance has no correlation to the client's evaluation and no correlation to outcome.

Michael Durrant
April 2024