“Feedback as means to enhance client-therapist interaction in therapy”


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The treatment context of this chapter is the Family Team at the Department of Mental Health for Children and Adolescents, Hospital of Drammen in Norway. Originally called the Family Unit, the current Family Team is part of the Ambulant Family Section at this hospital department. In 2002 we started to use two simple measures of outcome and process; Outcome Rating Scale (ORS) and the Session Rating Scale (SRS) (Duncan & Miller, 2000). The background for starting to use these measures was found in the following: a) The rationale for using measures of outcome and process as a way of supplying feedback to therapists fitted with some central ideas of the Family Team (that of following the perspectives, ideas and preferences of the family in building a tailored therapy) and b) as a response to the growing demand from both service user organizations and Norwegian Health authorities for creating an accountable practice.

When we started, we did not have a very explicit and well-formulated plan for the use of these measures. It was more a project characterized by the idea that “the road is built while walking.” Fifteen years later, we can look back and present central experiences and ways of working with service user feedback. These 15 years can be divided into three different periods. The first was a period of getting to know these measures and how we could use them. The forms of practices and ideas of use that developed during this period were more or less implicit and unformulated. After four years, the author was given the opportunity to pursue a Ph.D., which involved a qualitative study of the therapeutic practices of the Family Unit,
including studying the use of ORS and SRS, constituting the second period. Finishing the
Ph.D. in 2009 (Sundet, 2009) led to the commencement of the final period, now with
increased understanding and evaluations of the use of ORS and SRS. The following years
have expanded our understanding and ideas about using outcome and process measures and
what has become known as Routine Outcome Monitoring (ROM) (Boswell, Kraus, Miller &
Lambert, 2015) as a core aspect of the Family Team practice.

The ORS is used for monitoring the outcome of therapeutic work. In the understanding of the
Family Team, outcome is defined as what is happening concerning the well-being, goals and
preferences of the service user. We want to ask the question, as a result of therapy, are there
improvements in wellbeing and suffering from the service user’s relationship perspective?

The SRS is used by the Family Team as a means following the recommendations of
psychotherapy research and family therapy to track the development of therapeutic processes,
especially the therapeutic alliance (Bordin, 1979; Friedlander, Escudero, Heatherington &
Diamond, 2011). The client is asked, “In our current meeting and session, have you been
heard and respected? Are we working on the goals that you have specified, in a manner that is
within your preferences? Overall, how was our meeting and session today?” These questions
are important for the therapists because it appears that therapists are poor in predicting the
progress and process of therapy (Walfish, McAllister, O’Donnell, & Lambert, 2012).
However, feedback from the client to the therapist on these two scales can be a help for the
therapists to be better oriented to the development in the service users’ life and the effects of
what one is doing together in therapy.

After a small detour through the history of the use of ORS and SRS in Norway, the first part
of the chapter will present the main conclusion of the qualitative study done regarding the
Family Team. Furthermore, inspired by the work of Barry L. Duncan and Scott D. Miller, a
closer look at the Family Team’s version of Client-Directed, Outcome-Informed therapy
(CDOI) (Duncan & Miller, 2000) will be presented, with a focus on the main experiences and
understanding of our work with ORS and SRS. This will be done by looking separately at the
"CD" and the "OI" of CDOI1. The aim is not to give an explication of the CDOI, as Duncan
and Miller (2000) have discussed this way of working. Instead it is the aim to explicate how
we have come to understand CDOI, known as KOR in Norwegian, given our experiences of
having made the ORS and the SRS central to our work. This part serves as a foundation for

1 Thanks to Alicja Olkowska and Scott D. Miller for suggesting this distinction.
the last part of the chapter – what could be added to the client–therapist interaction that is facilitated by feedback? Attention will be given to the potentially novel aspects of this way of working. The importance of following the client and being challenged by data is suggested as being central to what could be seen as new.

A very short history of the introduction of Routine Outcome Monitoring and service user feedback in Norway

In the clinical domain within Mental Health Services in Norway, the dominant system of feedback have been what is known as CDOI, developed by Barry Duncan and Scott Miller (Duncan & Miller, 2000), and built around ORS (Miller, Duncan, Brown, Sparks, & Claud, 2003) and SRS (Duncan, et al., 2003). Emanating from a student group attending an advanced family training program in Oslo, in the beginning of the new millennium, the use of OSR and SRS and the ideas of CDOI spread as a bottom-up process into more and more clinical organizations in the Norwegian Mental Health services. At one point, a network was set up as part of the Regional Centre of Children and Adolescents Mental Health, East and South, under the leadership of Anne-Grethe Tuseth. In this Norwegian context, a teaching program for implementing ORS and SRS was created, a manual was translated (Duncan & Sparks, 2001) into Norwegian, a book was written (Ulvestad, Henriksen, Tuseth & Fjeldstad, 2007), and a DVD was produced with ideas and practices related to the use of OSR and SRS. After 2000, other feedback systems have been introduced in Norway, as this book shows and exemplifies (See other chapters). The focus of this chapter is the use of ORS and SRS and the practices, ideas, and perspectives that the Family Team now presents as content for CDOI. Much has been written on CDOI so the discussion here is abbreviated, but with a focus on our experience. The starting point for this is to summarize the findings from a study of our practices of ORS and SRS.

Client-Directed, Outcome-Informed Therapy in a family therapy context

ORS and SRS are both one page measures consisting of four items each in the form of 10 centimeter visual analogue scales. The ORS invites the service user to score and give feedback on the current feelings of the service user concerning her or his well-being (item 1), close relationships (item 2), work, school, and friendships (item 3) and the general sense of
well-being (item 4). The paper-and-pencil version that the Family Team uses informs the clinicians on a session-to-session basis about the development of the therapeutic work. Scores are computed by simply applying a ruler and measuring each item marked from left to right with a maximum high level score of 10, and a minimum low level score of 0. Accordingly, the total possible score is 40 and the continuous development of the outcome of therapy is expressed by physically drawing a trajectory on a supplementary sheet of paper. Scores below 25 are seen as the range where a need for therapy is indicated. Clinically, significant change towards recovery is expressed by an increased score of more than five points; recovery is expressed by a movement from below to 25 to above 25. Scoring within a range of five points of the initial score indicates that service user is not making significant progress and a decrease of more than five points from the initial score indicates deterioration (Miller, et al. 2003).

The SRS, also composed of four visual-analogue items and which is completed at the end of each session, was formed from Bordin’s (1979) concept of the therapeutic alliance and invites the service user to assess and give feedback about the session. Item 1 invites evaluation of the emotional bond while items 2 and 3 concern agreement on goals and methods. Item 4 invites the service users to score the overall experience of the session.

The Outcome Rating Scale and The Session Rating Scales as conversational tools

Sundet (2009) explored family therapy practices developed by the Family Team within the Department of Child and Adolescent Mental Health, Hospital of Drammen, Norway, with the aim of describing and better understanding these practices. The study was carried out in order to investigate the following research questions:

(1) What factors do families and their therapists identify as being essential for a helpful therapeutic practice?

(2) How do families and their therapists describe and evaluate the use of two measures, the Session Rating Scale (SRS) and the Outcome Rating Scale (ORS), in order to monitor therapeutic work?

Four therapists and ten families were interviewed and the interviews were analyzed using a modification of grounded theory. The analysis generated sets of categories specified by subcategories that supplied answers to the two research questions. The question of what
comprises helpful therapy converged on three overarching concepts: the helpful conversation, the helpful participation, and the helpful relationship (Sundet, 2011). The SRS and ORS were evaluated as feasible for clinical use, but involved difficulties that had to be attended to in the actual clinical situation.

ORS and SRS were described as conversational tools that gave rise to different conversational types and processes, an extension of their use beyond monitoring practice and supplying feedback on process and outcome (Sundet, 2012, 2014). From the perspectives of the therapists, OSR and SRS opened up conversations that gave feedback on the outcome and process of therapy. In addition, there was added value in that these measures also allowed for conversations that created structure, for conversations characterized by the not-knowing position (Anderson, 1997), for externalizing conversations (White, 2007), and for conversations that brought forth a product or result (see Table 1).

(Table 1 about here)

From the families’ perspectives, these measures also invited different conversational processes (Table 2). They initiated processes of communicating, inviting family members to express anything that came to mind, and more specifically, about areas of acceptance and change. With this, the ORS and SRS were confirmed to function in the expected manner, supplying feedback to therapists about the outcome and process of therapy. In addition, many family members reported situations in which they had difficulties verbally formulating why they had scored as they did. The score became a visualization of nonverbal impressions and further discussion in therapy gave these responses verbal content. This was a process of focusing the therapeutic work, moving from non-verbal impressions to verbalization of important material for the family. Third, the different items on the SRS and ORS represented different directions in which the conversations and work could be moved. Through questions about the scores, a process of structuring was set up. Conversations about the scores gave direction to the work, in addition to themes within this direction. For instance, a low score on item 2 of the ORS led to conversations about an internal conflict in the family and how to deal with this. The therapeutic work was then built around the continuously accessed feedback about this work. This meant that the treatment plan was continuously changing, directed by the feedback from the family. This changing movement represented the therapeutic work.

The use of the ORS and SRS also set up a process of exploration. The questions asked about the scores led to the discovery of previously unexplored areas. When this happened,
knowledge about a theme could be deepened and transformed into new options for meaning and action. With this, the idea of the measures as conversational tools emerged as an important aspect of therapeutic work in the Family Team. Here, tools are seen as something that mediates; by way of the tool, we increase the probability of bringing something forth. The clinical experience of the therapists working within these conversational processes have led to the formulation of three guidelines for practice.

(Table 2 about here)

The first guideline specifies that, as conversational tools, the ORS and SRS provide opportunities for questions, not answers. The scores on the ORS, the trajectories of the ORS scores over time, and the scores on the SRS have to be given meaning within the conversations between the family members and the therapists. In this view, clinical validity, reliability and feasibility are not inherent properties of the measures, but are always created within the conversational domain of the therapeutic work.

The second guideline states that when the service user is not improving or is deteriorating, the therapist needs to do something different. The Family Team gives priority to therapist change, in the sense that in order to do something different, the therapist needs to change her or his way of thinking, perspectives and/or ideas about how to work, and what to do. Such changes are experienced to have emotional effects in our clinical practice through experiencing them as possibly painful for the therapist. These changes, in the therapist's manner of working, is then guided by prompts, ideas and the theory of change of the service users. This means to combine the professional skills and knowledge of the therapist with responses from the service users. For the Family Team this is found to be in accordance with a pluralistic position (Cooper & McLeod, 2011) in which all kinds of therapeutic tools and manners of working can be braided together, guided and constrained by the service users’ responses.

The third guideline is that when a disagreement on how to proceed with the therapeutic work arises between service users and therapists, a process that gives priority to the service users’ perspectives, ideas, and preferences is set up. This, however, needs to take place within ethical boundaries. For instance, if a mother or father wants to use physical punishment as a manner of changing behavior problems in the child, the therapists will state that this is outside their ethical boundaries, and that they cannot take part in these practices. What they can do is to take part in conversations on the idea that physical punishment is seen as a good strategy for solving behavior problems.
The CD of the CDOI – The question of service user participation

Our experiences with ROM and the use of ORS and SRS have helped us to expand our understanding of psychotherapeutic work. One way of closing in on this understanding is through the concept of a family-based practice (Sundet, 2011). Central in this is the intertwining of the concepts of the helpful relationship, the helpful participation, and the helpful conversation. It is outside the scope of this chapter to present this way of looking at the content of psychotherapeutic work. Instead, as stated in the beginning of this chapter, another path will be taken in order to make more visible how we have come to understand our use of ORS and SRS, as well as CDOI. This will be done by looking separately at the "CD" and the "OI" of CDOI.

In our work in the Family Team, we identify two perspectives on the role of theory in psychotherapy. In the first, the uniqueness of each case and how it develops is paramount. Duncan and Miller cite Milton Erickson, who has said, "I think any theoretical-based psychotherapy is mistaken because each person is different" (Zeig, 1980, p. 131 in Duncan & Miller, 2000, p. 10). Furthermore, Duncan and Miller (2000) pointed out Steve de Shazer’s (1994) work that searched for a pattern to Milton Erickson’s successful cases. However the pattern was created, most of the cases ended up as miscellaneous. They seemed to be one-time idiosyncratic interventions that never were repeated. The conclusion drawn from this is that, "...Erickson simply listened carefully and then did what his clients told him" (Duncan & Miller, 2000, p. 11). This leads to the following questions. First, what should psychotherapy be based on? Second, what function do theory and research serve for psychotherapists? In the second perspective, theoretical coherence is emphasized. Wampold and Imel (2015) concluded that central to the Contextual Model is "...a cogent explanation for the disorder and concomitant therapeutic actions" (Wampold and Imel, 2015, p. 59). This again means that "...one of the common factors is the systematic use of some set of specific ingredients, delivered in a cogent and convincing manner to the client and accepted by the client" (Wampold and Imel, 2005, p. 59). With this, theory becomes an important part of psychotherapy, but not by specifying a deficit that must be changed or repaired by a specific ingredient, "...the Contextual Model posits that the specific ingredients in all therapies induce the client to do something that is salubrious" (Wampold and Imel, 2015, p. 60).
The experiences within the Family Team support both of these perspectives. On the one hand, we do not find that any one theory gives the families that attend the Family Team and their therapists the answer to how to understand the predicament and suffering that the family experiences, and the challenges and obstacles the therapists experience in working together with the families concerning their predicament and suffering. On the other hand, the therapists find that theory is necessary and helpful, and this means that the therapist may need many theoretical sources in their work (Sundet, Kim, Ness, Borg, Karlsson, & Biong, 2016). The question becomes what should guide our choice of theory and what does that theory do for us in our work?

The attention to "the CD" in this part of the chapter gives us some partial answers to these questions. The starting point for therapeutic work within the Family Team is always dialogues about the preferences, perspectives, ideas and prior experiences that the families bring with them concerning therapeutic work. This includes their theories of change (Duncan and Miller, 2000). Here, theory of change does not mean fully explicated and formulated theories in a scientific sense, but rather ideas on what would or could be helpful. The next experience that is central to the work of the Family Team is that the best way to continue the work is to follow the family and their ideas. This means that theory is also something that becomes more and more explicated during the therapeutic work, and that part of the job of the therapists is to introduce their knowledge base so that joint ideas of change can be developed, broadened and fitted to the predicament and suffering of the family. To do this, feedback from the family members is of the utmost importance. “Are we on track?” becomes the recurring question from the therapists. This also means that what theory does for both the families and their therapists, in addition to creating meaning and understanding, is to suggest therapeutic actions. Theory gives ideas on what to do. What are possible relevant actions given the predicament and suffering? Again, feedback becomes central because it is in the tracking of effects of these actions that we can get a picture of whether or not we are reaching the goals of changing the predicament and suffering. This will be addressed more fully below when looking closer at "the OI".

In Norway, service user participation is required by statute. It is literally a crime not to let the ideas, preferences, aims and needs of the client be taken into account when making and implementing treatment plans. Therapists who do not take these into account can be prosecuted. The argument of this chapter is that the concept of "CD" coincides with such service user participation. For the Family Team, this means to continuously include the
service user in conversations about how their preferences, needs, and important cultural elements can be realized in practice. Our therapy shall be fitted to these preferences, needs and cultural elements. That is the responsibility of the therapist. However, with this comes the situation of when the client and therapist disagree – when they see aspects of therapy and the client’s life, aims and means differently.

From the perspective of this chapter, it is the responsibility of the therapist to uphold the alliance, as well respectfully listening to differences, so the clients do not experience infringement and violation. This means that therapists’ change becomes a central responsibility of the therapist in relation to differences of perspective and opinion on what therapy is and how to do it. At times, this means that the therapists have to partake in ways of working and being together that may be contrary to his or her beliefs and professional perspectives. Does this mean that one must be a mindless therapist whose only job is to do what clients tell him or her to do? Of course not. The perspective of the Family Team is that conversations are one of the three cornerstones of a helpful practice, the other two being the helpful relationship, and helpful participation (Sundet, 2011). There will always be conversations and within these, there will always be differences – differences of perspectives, opinions, preferences, intentions, goals, and more. To attend to and work with these differences are central parts of the therapeutic work.

American sociologist Richard Sennett makes a distinction between two types or classes of conversations – dialectical conversations and dialogical conversations. "In dialectic conversations, the verbal play of opposites should gradually build up to a synthesis;... the aim is to come to a common understanding," (Sennett, 2013, p. 18). Dialectic conversations are about establishing common ground. Here, the difference between the perspectives of the clients and their therapists, seen as thesis and antithesis, is at some point transformed into something that is different from these two positions, a synthesis. A third, new state is reached and the participants develop a sort of emotional rest, tranquility, or acceptance of this new situation or state. In therapy, one could imagine this as negotiations on how to proceed together (Strong, Sutherland & Ness, 2011). For instance, what is the aim of the session and what tasks should be used in reaching this aim? Strong and colleagues (2011) suggested that negotiations are at the core of such conversational transactions. "...we develop our sense of being ‘on track’ with each other, by being responsive to each other’s initiatives and reactions, in negotiations and inter-subjective modifications ..." (Strong, 2010, p. 384–85). Through
such conversational processes, a third state can arise, either as a deliberately reached conclusion or a spontaneously arising state of agreement.

Dialogic conversations do not resolve themselves by finding common ground as in a dialectical conversation: "Through the process of exchange, people become more aware of their own views and expand their understanding of one another" (Sennett, 2013, p.19). Therefore, in dialogical conversations, difference is approached in another manner. We can still talk about negotiations, but we are not referring to them as a process that produces a new goal, state, or resolution to whatever problem is under discussion. Now the negotiations conserve or secure a difference. Think of a conversation between parents and a therapist on the use of systematic exposure training. The parents had experienced that prior trials with this technique had led to increased suffering and symptoms for their child. Therefore, they wanted to see if there were other treatment options. The therapist upheld that he believed that systematic exposure still would be the best option, but accepted after awhile, due the negative experiences of the family, that they would seek out other options. The family accepted the perspective of the therapist by saying that they would reconsider using it again if other options weren’t found, but at the moment they preferred searching for the other options. By this, the difference of the family and the therapists was conserved. This implied an emotional difference also. There existed an emotional tension between parents and therapist due to the different views and preferences. All the involved parties were made aware of this tension by the fact that one part of the difference, the preference of the therapist, was abandoned. At the same time both the tension and the upholding of different perspectives implied an acceptance of this situation. In a dialectical conversation one would expect that this tension and difference would be solved by establishing a third option. In our example, working within the described tensions of a dialogical conversation, led in the end, to a third option that they all could agree upon (see below). As such, the dialogical conversation developed into a dialectical one. In other such predicaments, where participants hold different views and preferences, the upholding of difference can lead to each participant becoming more aware of their own views and expands their understanding of one another. Again and again, in for instance therapy with divorced couples having fights about what is the best and most secure rearing practice for their children, accepting that they do things differently may lead to the child being brought out of the war zone that such fights often are. There is no resolution of the difference in the sense that they agree on rearing practices. Instead they accept -each other's
way of doing things, both with new understanding of the other, but maybe still with a fear that the other’s solution is not good enough. Acceptance and tension are both present.

The Family Team has found that in working with differences – differences between us and the family members, between us therapists, and between the family members – the use of ORS and SRS are of the utmost importance. The Family Team has found that any spontaneous or reflected understanding of and decision about the process and outcome of the therapeutic work must be corroborated by actual feedback from the family members. This is not because we are bad therapists, but rather it is because therapists are people. We are, as a species, bad at such clinical judgments (Meehl, 1954). Secondly, because clinical judgments are defined as part of professional knowledge and competence, there is a possibility that we use the theory of the method to explain good outcome, while outcome failures are explained through the theoretical concepts of the therapy applied. Typical examples here are the concepts of resistance and lack of motivation, while a new option is the patient’s lack of mentalization capacity or ability. These types of judgments are seeds of infringement and violation. As responsible professionals, we need to take seriously the idea that we are dependent upon prompts, ideas and directions from the clients. We are dependent upon the response of our clients to our responses of their responses ad infinitum.

In the work of the Family Team, we do not experience this as problematic tension. In fact, the Family Team is part of The Ambulant Family Section, Department of Child and Adolescent Mental Health, Hospital of Drammen, where there is one other team. This team works with the Parent Management Training – Oregon model (PMT-O), which is an evidence-based method (Patterson, 1982). What we see is that flexibility is a characteristic of both of these teams. There is an agreement that therapy must be fitted to the family. The difference is that in the PMT-O team, the family is invited into a specific method with clear rationale and concomitant therapeutic actions, which are executed flexibly and in collaboration with the family. At the same time, when preferences, problems, and/or diagnostic issues arise that do not fit with the rationale and concomitant therapeutic action of PMT-O, the Family Team can be invited in and PMT-O is terminated. Likewise, in the Family Team, when the preferences and needs of the family fit with the rationale of PMT-O, this team can be invited in and contact with the Family Team is terminated. This means that the Ambulant Family Section has diverse manners of working that can fit a larger variety of the client population compared to if there was only one of these teams working. The demand that is on the therapists in both
teams is to accept both that there are limits to one’s own way of working and that there are other ways that can helpful.

At the time of this writing, we are also implementing the use of ORS and SRS in the PMT-O team. The preliminary conclusion is that these measures should be used in a different manner in these two teams. In the Family Team, they are used with "CD" and "OI" (see below) of CDOI. In the PMT-O Team, ORS and SRS are used to support and develop how the family and therapists can best apply and use the principles, rational, and therapeutic actions of PMT-O. What both teams have in common are the necessity of tracking the effects and the outcome of what we are doing. Again, we are dependent upon the responses of our clients, and not only as prompts for how to secure "the CD"-manner of working, but also regarding the "OI", that is the effects of our therapeutic work.

*The OI of the CDOI – The question of being informed by data*

There are now computerized systems for the use of ORS and SRS, such as the Partners for Change Outcome Management System (PCOMS) (Miller, Duncan, Sorrell & Brown, 2005; International Center for Clinical Excellence, 2013) and the Feedback Informed Treatment-Outcomes (FIT-Outcomes) (Miller, & Bertolino, 2011). In these systems, outcome data can be aggregated to a group level, enabling therapists to compare themselves with their own usual outcome, and with those of their colleagues. The therapist’s team or institution can also track its outcome over time, so that levels and developments can be traced, enabling the leaders and stakeholders of the institution to make comparisons with other institutions’ outcome. The Family Team has not had access to such a system. Instead, the ORS and the SRS are used in a paper-and-pen version\(^2\). This means that our conclusions on the continuous outcome of the therapeutic work are made through conversations with the family members. This is consistent with the Family Team’s emphasis of using the measures as conversational tools. At the same time, we lack and cannot get the feedback supplied through the aggregation of data across cases, therapists, teams and sections within the Department of Children and Adolescents Mental Health. This must be kept in mind in the following discussion regarding our experiences with "the OI" of CDOI.

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\(^2\) The Ambulant Family Section is now working on implementing such a computerized system.
Elements of CDOI in an ambulant family therapy team, as it was presented in the beginning of this chapter, can be clinically exemplified in the following manner. Take, for example, a father who was not used to talking in the context of treatment in a public healthcare unit. Talking about the scores of ORS "got him going," which, through a process of communication, led him to be able to state what he wanted for this family. In another family a young girl was not able to verbalize her feelings. A process of focusing was initiated through the scores, which made her able to move from the "non-said" to the "said," expressing feelings of shame. In a third family life was in full upheaval, with multiple challenges and problems in their lives. A process of structuring was initiated through the conversations around the scores on the ORS, which moved the family from chaotically expressing a multitude of issues to agreeing on the theme they felt was most important to work on in the present moment – how to be able to start the morning without a quarrel. A final example is the family who, through discussion about the trajectory that was drawn from the ORS scores, set up a process of discovery concerning their twins and their ability to keep a caring relationship with both of their grandparents who were currently ill. In this process, the parents' view of their children was moved from seeing them as non-social and worrying about lack of empathy, to stories of empathy, concern, and involvement in family issues in a productive manner. The mother’s words in the end of this process concluded, "I do not know where I have been. I have only seen problems and that has clouded my view. It is like not being able to see the forest because of all the trees. Thank God I discovered these other sides of my twins."

In all of the above examples, it was the scores, the outcome reported in every session, that signaled no-change or detrimental development that became the starting point for the conversational processes. This is what OI is all about and also exemplifies our first guideline – the ORS and the SRS give opportunities for questions, not answers. It is the conversations and their development that clarify what the outcome is in every session of therapy. The answers are given by the service users in the conversational processes. Here, feedback is about the conversations that the scores on ORS and SRS lead to. Scores on these scales must be given an interpretation – a specific and concrete meaning contextualized to the actual life of the client and the events within the processes of therapy that service users and therapists create and are part of. To be informed by data means here that this is done through conversations about the data – individual scores on ORS and SRS. At the same time, the scores on the ORS
and the trajectories that can be drawn over time, and every single score on the SRS, also function as a "warning signal" (Lambert, 2010).

Seeing the scores in themselves have potential effects. The scores are signals about either being “on-track” meaning that everything is in agreement with the desired goals, or “not-on-track”, meaning either that nothing is happening or the experience of the family members is one of deterioration in well-being and development. These two modes of CDOI, the generation of conversations and the "signal-effect”, together point to the importance of the second rule of practice – under conditions of failure to make progress (either no change or deterioration), the priority of the therapist becomes to change something about therapy, as defined above. The outcome for every session leads to questions about how to continue the work. Are we “on-track”? If not, what changes in the manner of working does this induce in the therapists? Often at the point of identifying not being “on-track” is the experience of being at an impasse or a situation where the therapist is uncertain how to proceed. The conversational input from the family or the "warning signal" becomes the occasion for searching both conversationally with the family and in parallel to one’s own professional knowledge base.

Searching for and within theories that can give ideas to or suggest therapeutic action becomes a central part of the work of the therapists. Likewise, research-based knowledge becomes such a source, where one important part includes theory-specific methods that have been tested in randomized control trials and established as having an effect on the group level. We are back to the situation where one option in the Family Team is to invite colleagues from the PMT-O team, in addition to including elements from other forms of theory-specific therapies, like cognitive therapy (Beck, 1995). These become important sources for getting out of the impasse or finding new avenues to give both therapists and families hope. Therefore, in the work of the Family Team, "to be outcome-informed” is more general in that the information is not limited to ROM. This has led to two particular metaphors concerning how to group psychotherapeutic methods and practices.

These two metaphors are grounded in experiences we have in working with the special target groups of the Ambulant Family Section. These are, first, families that have tried other forms of therapy and did not find them to be helpful. Second, it includes families who are in need of a more intensive process (more and longer sessions for instance), and that one can be ambulatory in nature (work in people's homes or at school for instance). Third, the Family
Team can be useful in therapy processes where collaborative problems have risen in the relationship between families and their prior therapists. In all of these groups, the experience of the Family Team is that the third guideline is fundamental – when a disagreement on how to proceed with the therapeutic work arises between service users and therapists, the perspectives, ideas, and preferences of the service users are given primacy. This has led to two metaphors of "yes"-oriented and "no"- or "hesitation"- oriented methods. First of all, we have those methods that depend upon the "yes" of the client. This implies "yes" to the method offered by the therapist and its theoretical rationale, explanations and suggestions for practice.

In the Ambulant Family Section, the work of the PMT-O team exemplifies this group of methods. These methods are characterized by clearly stated theoretical underpinnings. They consist of theory-specific factors that illustrate how to understand the problem and its etiology, as well as how to move out of or be healed from the disorder or the predicament one is in. The model theoretically specifies the path to remoralizing and healing in a clear manner.

The other group of methods is characterized by the client saying "no" or being hesitant (Rober, 2002) to the manner of working that the therapist suggests. This can occur either in the initial therapy contact when goals are specified, or it can happen during the therapeutic process of working with the client’s problems or predicament. In both groups of methods, feedback is necessary, but is used in different ways. In the first situation, feedback is used in order to secure the client’s participation in what the theory-specific manner of working specifies. The feedback is a means to help the therapists to be better off helping the client to accept and attend to the demands of the method. Straying from this, protesting or being hesitant will, at worst, be interpreted by the therapist as a lack of motivation, and at best, as a poor fit between method and client that could point to the need to change the method. The "no"- or "hesitation"- oriented methods are, by definition, theoretically and practically pluralistic (Cooper & McLeod, 2011). In the Family Team, the aim is, through the responses of the client, to build a manner of working therapeutically that fits with the preferences of clients. The field of psychotherapy is seen as a huge toolbox, concerning ways of explaining and understanding both the suffering of people and how to meet such suffering in a remoralizing or healing manner. It is framed within a trial-and-error oriented way of working, where feedback, especially the "no" or hesitations to suggested ways of working, is the decisive and necessary part of the work. It is through a "no" or hesitations that we know where not to go. In our daily practice, these metaphors help us retain and accept the
differences between the Family team and the PMT-O Team, and, through this, create space for the diversity of practices that characterizes the Ambulant Family Section.

Continuous conversations around feedback are the driving force of this manner of working. For example, in our practice, we meet children and adolescents who refuse to do systematic exposure training with their anxiety or OCD problems. The trial-and-error oriented manner of working has given us experiences that, instead of focusing on exposure-based interventions (Dobson & Dobson, 2009), there is a focus on areas of intentions, aims, wishes and desires of the child or adolescents, regarding what they would like their life to become. Interviewing the above mentioned teenager who refused to do systematic exposure training on what led her back to the classroom that she had refused to go into, she said, "My desire became greater than my fear". The path to change was not systematic exposure training, but rather, it was a focus on important life issues and her desires and hopes for the future. At best, we can say that exposure was an end result, but was still trivial compared to the focus on desire and hopes. The work of the Family Team is best identified as part of the "no"- or "hesitation"-oriented group of methods and ways of working. Feedback from the service user becomes of the utmost importance here, because the therapeutic work is dependent upon catching every sign of a "no" or a hesitation. This points to where not to go in the therapeutic work. Conversations on where to go and how to proceed can gradually be developed. This is learning by doing.

Fundamental to the work at the Family Team is the notion of collaboration. In this area of our practice CD is self-evident, and OI is invaluable. Again and again our experience is that clinical judgment is biased and unreliable. This is especially important in collaborative work. Sundet, Kim, Ness, Karlsson, Borg and Biong (2016) suggested an understanding of collaboration built around the concept of turn-taking. Arising within developmental psychology (Bateson, 1975; Stern, 1985; Sundet, 2004), turn-taking points to the mutual responding and responsiveness that is at the base of infant–caretaker interactions. As a metaphor for psychotherapeutic interactions, it states that the first step to any psychotherapeutic effect is the establishment of turn-taking – mutual responding to each other's responses. This way of thinking about the starting point and necessary condition for a psychotherapeutic venture circumvents the notion of motivation and it places the responsibility for establishing such turn-taking to the therapists. Here, responsible means "to be response-able" (Haraway, 2008, p.71). The task of the therapist is to be able to respond to the service user in such a manner that the turn-taking, the process of mutual responding, can
continue. The importance is that when a stop or an impasse in the process of turn-taking, either as verbal or non-verbal transactions, happens, the job of the therapist is to find a way of responding to the service user that makes it possible for her or him to respond back. Here feedback from the service user about both the continuous outcome of our collaborative work, and how the therapeutic alliance develops, is invaluable and necessary. When such turn-taking is established in a stable and repetitive manner, the next step is that the content of this turn-taking becomes a process of negotiating the goals and tasks of the collaboration. "What is it that we want to achieve together?" In the therapeutic context, this is equivalent to the goals and task parts of the therapeutic alliance (Bordin, 1979).

The last step in the process of collaboration is that the turn-taking becomes a process where the differences in lived experience, position, perspective, knowledge, and preferences of the participants in the collaborative endeavor are used in order to reach the agreed upon goals, through the tasks one has chosen to apply. This is referred to as “putting differences to work” (Sundet et al., 2016). Richard Sennett's (2013) concepts of dialectical and dialogical conversations are two examples of what we mean by “putting difference to work.” In the above example of the girl with a social phobia, the perspective of the therapist on the use of exposure-training was challenged by the mother who insisted that there must be other ways of reaching the goal of helping her back to the classroom. As stated before, in this example, a period of living in the tension of a dialogical conversational process happened. After awhile, the difference between the mother and the therapist initiated a search of the therapist for theoretical sources other than those related to exposure-based interventions, which led to a synthesis, a third state that fitted both the mother and the therapist. For the therapist, this was rooted in descriptions from developmental psychology that underlined the importance of affect regulation and increasing the agency of the girl, to a practice where her goals and suggested tasks were systematically followed (Stern, 1985). This included inviting friends to alternative classrooms. These actions increased her desire for more contact with peers, which led her back to her classroom. Her increased desire seemed to displace her anxiety. Running through this kind of collaborative work is the result of the therapist’s dependency upon feedback from the family members. Collaboration and other aspects of the therapeutic relationship must always be constrained by the outcome of our work together. The OI must be braided in with the CD. That is what CDOI is all about. One of the temptations that we found in our collaboratively-oriented work is to be satisfied with good collaboration and therapeutic relationships. Our experience is that this is a necessary condition, but is not enough. As a
father stated, “It is not enough to sit here and talk friendly; sooner or later, we have to do something also.”

**What could be new in client–therapist interactions as a result of feedback?**

This chapter has given a description of a version of CDOI, known as KOR in Norwegian, developed in the Family Team. This has been done, for descriptive reasons, by separating the "CD" and the "OI" in CDOI. It must be underlined that in actual practice, these two components cannot be separated. They are mutually interdependent. Given the description of these two components, is there something that could be deemed "new" concerning therapeutic client–therapist interactions?

What is the new and how do we know it is new? For whom is it new? The new can be seen as something that is outside, or that disturbs, the traditional way of thinking. It changes our traditional and accepted ways of attending to and understanding a phenomenon, or engaging in a practice. Is there something new along these lines in the above? Let me therefore summarize what could be deemed as possibly new (for some therapists).

*The potentially new*

To summarize the previously presented experiences, research gives us, at the moment, a strong argument for the use of client feedback and ROM, at least in cases that are not on track. Second, there are clear signs that supplying information to therapists on outcome over the course of therapy is important. Third, there are indications that conversations around and about the feedback with the service user are important both for outcome and for the experience of the therapist as being responsible (Sundet, 2014). This puts service user participation at the core of therapeutic work, and as such, participation means that therapist responses are subsumed under or constrained by the service user’s response. In the work of the Family Team, this has led to the three guidelines – that the ORS and SRS give opportunities for questions rather than answers, that impasses create therapist change, and that service users’ perspectives and preferences are given priority. This means that therapist change is a necessary activity and skill in any therapeutic endeavor.
Failure to progress in therapy, as documented through ROM, should elicit from the therapist a change in the therapy process, which is needed before client changes. This does point to the relationship between the client and therapist as being asymmetrical and egalitarian. It is asymmetrical because clients and therapists are in different positions and roles, with different perspectives and knowledge. There are different demands, and service users and therapists have different responsibilities. It is also asymmetrical because in the end, it is the voice of the service user that decides if he or she has been helped, been remoralized or reached the goals of therapy. These differences point to the fact that in a collaboration, putting differences to work is central. Furthermore, the relationship between service user and therapist is egalitarian because no position is superior. No voice has more value compared others and no voice should be marginalized. By working within a team that tries to follow the above, our experience is certainly that we are in opposition to some perspectives that uphold the idea that helpful practice seems to depend upon the client always subsuming him or herself under the rationales of the therapy offered. The division onto two groups of methods—"the yes-oriented" and the "no"- or "hesitation"- oriented— is our way of creating the relationship -between theory-specific and eclectic and pluralistic manners of working as a supplementary relationship and not one of opposition. At the same time, it gives space and opportunity for the family members to partake in creating their own therapy.

The third guideline implies that it is an important skill of the therapists to be subsumed under the perspective and preferences of the client, and as such, to be a therapist is to acknowledge one's dependency upon the responses of the client. We uphold that for many, this will indicate a new manner of being together with clients that will have obvious consequences for how the interactions and conversations between clients and therapists are carried out. Parallel to this, the exposition of the OI above points to the fact that the situation is more complicated than simply either following the client or the therapist. Following theory-specific treatment principles and practices offered by therapists has a sound evidence base. People are helped by following the therapists. This definitely violates the beliefs of those who think that therapy is only a singular event consisting of one-time idiosyncratic interventions that are never repeated. One way of relating to this is to acknowledge the randomized clinical trials and naturalistic studies to support the notion that psychotherapy is helpful both under experimental conditions and in actual clinical practice. (Lambert, 2013).

However, this can also be viewed from another perspective. It can be stated that when you have an evidence-based method, it is also shown in the evidence that some are not helped.
This means that in a responsible clinical practice, one must be prepared for the situation that a particular way of working will help some and not help others, and the big question is what to do about those who are not helped. It is through our accepted and preferred ways of working that we help people (Wampold & Imel, 2015). We need to believe in what we do and we need to have expectations that we will be helpful. When we meet clients that are not helped by our preferred and believed manner of working, these clients represent something new. On the one hand, they violate our beliefs, but on the other, they represent an opportunity for us to learn something new.

To be outcome-informed (OI) means, in this chapter, to embrace two sources of knowledge. One is the nomothetic knowledge that points to what is generalized and what is found to be the case on a group level. This knowledge source invites both therapists and clients to act within a set of principles, a rationale, and the consecutive forms of practice. Feedback from the client, as idiographic knowledge, is used to help the therapist design and bring forth the principles of treatment in new manners that fit the client. Our experience from the PMT-O therapists’ work is that it sometimes seems that there are almost unlimited ways of realizing the principles and rationale of PMT-O. Therapists’ creativity within the model is therefore the core of this way of working.

At the same time, there are also limits. There are situations where one has left the rationale and instead invites new, principally different manners of working. Given the set of principles one has been working within, our experience is that when leaving these, uncertainty arises. This is where we find the use of "no" and hesitations so important. A new manner of working is set up where we are naturally in a not-knowing position (Anderson, 1997). A not-knowing position is not a knowledgeless position. It is a position where it is open to what will be helpful, and we need to set up a process of discovery together with the service users. The therapists still have their nomothetic knowledge with them, but what can be of use must be discovered together with the clients. Again the idiographic aspect of knowledge is necessary and invaluable.

In the last instance, it is the response of the clients that determines where to move on. This is a process of moving about and finding our ‘how’ to go on (Shotter, 2008). Australian narrative practitioner Michael White (2007) called this process "loitering". It might seem aimless and haphazard, or what the Boston Change Process Study Group (2010) calls a sloppy, uncertain, dynamic, and potentially creative process, but it gives rise to discovery. Here, feedback is not
used in order to be kept within a set of theory-specific principles, but rather, it is used in order to generate new principles or discover which other principles would fit the client. This is where we think that we all easily can be intimidated by the new. Whatever position we take, there will be positions that are experienced as new in the sense of violating some belief or principle that we hold. This means that in being confronted with theory, there will always be challenges that seem paradoxical or irrational, but which find their way in the actual practice of the service users and therapists. It is the view of the Family Team that dilemmas cannot be solved – they must be lived. In such a position, I, as a therapist, am completely in the hands of the client. It is through the responses of the client, both on the standardized feedback forms that we use and through the conversational responses and interpretations they offer us on these, that we can find grounds for continuing the path that we are on. One important skill that seems to be decisive and necessary in order to be able to work in this manner is to follow the client. What does this mean?

To follow the client and be challenged by data

What do we mean by following the client? Either by working within a theory-specific or a theory-pluralistic manner, the response of the client will be decisive for how the therapist proceeds. The general understanding argued for in this chapter means that we need feedback in order to assess if what we are doing actually leads towards the preferred or stated goals of the service user. In the theory-specific group of methods, the "yes"-oriented methods, the principles and rationale of the therapy, will always set limits for what kind of adaptation or fit that the client can do and still be within what the method demands. At the same time, it must be repeated here that the experience with PMT-O sometimes gives the feeling that there are almost unlimited ways of realizing the stated therapeutic principles, but this is qualified with the experiences that although this feeling is there, there are limits. There are actions within the session that bring the therapeutic work outside of the theory-specific boundaries of PMT-O. In the following, I will therefore focus on what "following the client" in the theory-pluralistic way of working implies – "the no" or hesitation-"oriented" methods and practices that this chapter argues for as a supplement to the "yes"-oriented methods.

Following the family has the superior aim of establishing a manner of working therapeutically that fits with the preferences and personal and cultural beliefs of the clients. The slogan for this work is "tailoring treatment". To manage this, it is of the utmost importance to have a
focus on the ideas, perspectives, understandings, and theories of change of the client, together with stated goals. This is to establish a joint focus, but one that is always governed by the perspectives of the client. It implies focus on two levels — on the verbal, meaning oriented level, and on the expressive–affective level of the body. The first can be seen as a meaning-oriented macro-level, and the second a bodily micro-level showing itself in the gestures, tone of voice and other aspects of body language. On the macro-level, verbalized joint understanding is at the core of the work. The job of the therapist is to make certain that he or she has an understanding of what the client communicates or wants to have an understanding of. This means that the conversational processes of therapy are more directed at what the client and therapist can understand together, rather than for the therapist to create some theoretically based understanding of the client. The hermeneutical triangle where two (or more) persons struggle to understand a third state of affairs is a more fitting model here, compared to a classical psychological orientation where the job of the therapist is to create or give an understanding of the client (Torsteinsson, 2005). The asymmetry of the relationship shows itself through the fact that it is, in the end, always the material of the client that is in focus. We consider the therapist’s contribution in such conversational processes in order to not exclude her or his perspectives, generalized and personal knowledge or clinical experience. Rather, the role of the therapist is to put these into play in the conversational meetings and, through the responses of the clients, gradually build up an understanding of what needs to be understood to bring about the goals and the preferred state of the client.

On the micro-level, ‘to follow’ especially means to allow oneself, as a therapist, to be moved by or be in resonance with the affective expressions of the client. The concept of attunement is descriptive of this state of affairs (Stern, 1985). Our experience is that hesitations, in particular, express themselves through gestures, tone of voice, facial expressions and other bodily responses. These are vital signs that point to both important directions that either should be followed or avoided, and signs of themes that need to be investigated conversationally together. We follow the perspective on conversations that in each moment, the participants respond towards each other on the basis of anticipated responses of the other (Shotter, 2010). Especially important for the therapist is to follow the anticipations she or he has about how and where the conversation should go. When these anticipations are disqualified or not confirmed, one should seek help from the client on where to go. Rupture-and-repair, disconnect and reconnect (Safran & Muran, 2000; Tronick, 2007), are therefore key conversational elements in this kind of work.
At the same time, we acknowledge that sensitivity towards hesitations and other responses that can guide us is not enough. Therefore, this way of working is dependent upon using standardized measures like ORS and SRS. This is beneficial partly because the scores on the ORS and SRS serve as signals about when we were not able to follow the client, and partly because they serve as conversational opportunities. This brings us to ROM as a procedure and tool for gathering data on ourselves as therapists and on the work done in the unit, team and/or organization that we are part of. Data used for research purposes, but more importantly, data gathered over time, can become new sources of feedback. The data give rise to opportunities for comparisons with oneself ("Am I performing as I usually do with these kinds of problems?"), with colleagues ("Why are my outcome different from my colleagues?") and other teams/organizations ("We have higher/lower end results than does team/organization XX – why?").

The collection of outcome and process data through the use of ORS and SRS means accessing a perspective where I, as a therapist, can see myself from the outside through the pattern of the aggregated data on my work. The data aggregated will make possible comparisons with my outcome in prior cases, as well as with the expected development from the data based on large numbers of clients. Research suggests that we, as therapists, are not particularly good at assessing the effects of our own work (Walfish et al., 2012). We need to have a belief in our way of working, but we also need to be confronted with the possible lack of effects of what we do and the idea that we may be partaking in the process of therapy in manners that are not helpful.

As stated above, we need to do this at every moment in therapy, and at the same time, accept that this vigilance is not enough. We need feedback from the outside. We need to be in resonance with the clients at every moment of therapy, and at the same time, we need to receive help from the outside to assess if we actually are on track with seeing the client from the inside. More precisely, in the language of this chapter, we need outside information from the clients and from comparisons with our prior results and the results of other therapists. This is needed in order to be able to understand something together with our clients and bring therapeutic actions to life that fit the client in a helpful manner. Working as a therapist, therefore, implies a paradox or an existential dilemma where we are both doomed to follow the client and at the same time, also be doomed to fail in this. It is through the repair and rectification of these failures that we become part of a successful therapeutic collaboration. The work of the Family Team suggests that without formalized feedback and Routine
Outcome Monitoring, it is not possible to come out of such a dilemma in a productive manner.

**Closing remarks**

The use of and work with OSR and SRS in Norway are deeply indebted to the work of Barry L. Duncan, Scott D. Miller and Jacqueline Sparks. Their original work with CDOI and the continuation of this work in their new separate institutes continue to inspire and guide the work with ORS, SRS and ROM in the Norwegian context. This means that what has been described and presented in this chapter is a version of their work. At the same time, when ideas are imported into new contexts, there might arise new forms of practice and different interpretations of the original work. Furthermore, it is hoped that the original work spurs the search for new theoretical sources and information on how to deal with the demand for research-based practices. Any newness in this chapter will certainly be a replication of the original ideas, while at the same time being a supplement where the repetition also includes differences (Deleuze, 1994). This chapter is therefore an invitation to let the ideas presented inspire and be a point where the reader may create her or his own versions of this work. They are not offered as something that should be replicated, but rather, as something that, in the end, will elicit new forms of practice that can still be seen within the landscape of ideas that CDOI represents.

**References**


Table 1. The therapist perspective

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<td>… for conversations about feedback, progression and change.</td>
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Table 2. The family perspective

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<td>To express and tell</td>
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