Sexual Abuse:
A Journal of Research and Treatment

SAGE
the natural home
for authors, editors & societies

Tuesday, March 10, 2015

The Emerging Use of Feedback-Informed Treatment with People Who Have Sexually Abused

David S. Prescott
Valerie Gonsalves
Jim Reynolds
Scott D. Miller

SAJRT Bloggers' Profile
Chief Blogger Kieran McCartan, Ph.D. and Associate Bloggers David S. Prescott, LICSW and Jon Brandt, MSW, LICSW are longtime members of ATSA. We are dedicated to furthering the causes of evidenced-based practice, understanding, and prevention in the field of sexual abuse.

Overview

This blog post explores the use of ongoing structured client feedback in adherence to the responsivity principle of effective correctional treatment. After an introduction to the concept of Feedback-Informed Treatment (FIT), it describes the work of two ATSA members who are using FIT in very different settings.

Background Information

In an important study of what works in group treatment of people who have sexually abused, Beech and Fordham (1997) stressed the importance of attending to therapeutic processes and cohesion in group treatment and found that therapists typically rated themselves as being more helpful and concerned than their clients did. Indeed, client perceptions are more influential in treatment progress than therapists' beliefs about their own skills (Orlinsky, Grawe, & Park, 1994). Despite what professionals want to believe, we are not the best judges of the therapeutic alliances.

At a time when our field argues whether treatment for people who have sexually abused works, many (e.g., Prescott & Levenson, 2009) have wondered whether our field is actually asking the right questions. Perhaps the most important question is what professionals can do to create programs for clients who may be at risk for refusing treatment or dropping out to "get it" and make meaningful change (Marques, Wiederanders, Day, Nelson, & van Ommeren, 2005).

What is clear, however, is that findings of the past decade have cast confrontational approaches into a much less favorable light (Marshall, 2005; Parhar, Wormith, Derkzen, & Beauregard, 2008). In fact, in an influential article regarding addictive behavior, William White and William Miller (2007) stated:

There are now numerous evidence-based alternatives to confrontational counseling, and clinical studies show that more effective substance abuse counselors are those who practice with an empathic, supportive style. It is time to accept that the harsh confrontational practices of the past are generally ineffective, potentially harmful, and professionally inappropriate.

An emerging body of research in the behavioral health field indicates that incorporating formal feedback regarding progress and engagement into treatment services builds responsivity while simultaneously improving outcome and retention (Prescott & Miller, 2014, 2015). Feedback-Informed Treatment (FIT) has been successfully integrated into both mental health and substance abuse services, serving both voluntary and mandated clients, in agencies and systems of care around the world (Bertolino & Miller, 2012). Multiple randomized clinical trials document that adding FIT to existing treatment services as much as double the effectiveness of the care provided, and reduces attrition and deterioration rates by 50% and 33%, respectively (Miller, Hubble, Chow & Seidel (2013).

FIT involves administering two scales over the course of treatment; one measuring the quality of the therapeutic relationship (the Session Rating Scale [SRS]), and the other assessing progress or outcome (the Outcome Rating Scale [ORS]). Over 1,100 studies have made clear the importance of the therapeutic relationship to treatment outcome (Duncan, Miller, Wampold, & Hubble, 2010). Indeed, in an era that emphasizes evidence-based practice, the therapeutic relationship is the most evidence-based concept in psychotherapy research (Bargmann & Miller, 2011). Understanding changes in the relationship can help ensure that clients are meaningfully engaged in change efforts, assist treatment providers in adjusting their strategies to meet each client's needs (thereby adhering to the responsivity principle), and act as an early warning system for treatment deterioration and failure. At the same time, research has demonstrated that changes in a person's individual, relational, and social functioning are strong predictors of successful therapeutic work (Bargmann & Miller, 2011; Miller, Duncan, & Hubble, 2004).

As research to date shows, access to real time feedback regarding progress and engagement provides clinicians with an opportunity to adjust services in a way that enhances individual client responsivity and achievement of treatment goals (e.g., decreased reoffending). The same body of evidence documents that FIT promotes professional development, resulting in measureable improvements in individual provider responsivity and effectiveness (Miller, Hubble, Chow, & Seidel, 2013). In 2013, FIT was deemed an evidence-based practice by the Substance Abuse and Mental Health Service Administration (SAMHSA) and listed on the National Registry of Evidence Based Practices and Programs.

Of course, evidence-based practices in the field of treating sexual aggression involves adherence to the principles of risk, need, and responsivity. FIT is best thought of as improving adherence to the responsivity principle. As the two vignettes below illustrate, programs adhering to the risk and need principles can further build responsivity by using FIT. The big question is whether the treatment provider and his or her agency is ready for the challenge of listening to their clients' feedback and open to the professional self-development that follows. Changing one's practice to meet the needs of clients is not easy. Indeed, maintaining a stance of eager anticipation about what one can learn from their client is vital to collecting the most helpful feedback.

FIT in a Sexual Offender Civil Commitment Setting (Valerie Gonsalves)

At the beginning of each session, I have the patient complete the ORS. If there's a particular area that rates low, we can direct attention to that area. If there are inconsistencies between unit report and patient report, it can open up the discussion about those areas. For example, if someone received three or four sanctions in a week, but reports that they are doing well overall, raising this discrepancy can provide a nonjudgmental manner of addressing the sanctions. Similarly with the SRS, I administer

this instrument at the end of each setting. For patients who may be hesitant to provide feedback or may experience distrust about the nature of the relationship, the SRS can serve as a launching point for conversations about alliance. I typically expand my discussion of alliance to include variables that have been found to be specifically relevant to mandated therapeutic relationships, such as trust, caring and fairness, and toughness (Skeem Louden, Polaschek, & Camp 2007).

Notably, in a civil commitment the mandated nature of the therapeutic relationship can serve as a barrier to accurate reporting. Patients may be frightened of experiencing negative consequences, either legally or within the institution, if they provide the clinician with an honest assessment of their current functioning or suggest an area for therapist improvement. As such, these patients typically demonstrate consistently high ratings on the ORS and the SRS. When this occurs, it can serve as a launching point for a discussing about meaningful treatment engagement or that the therapist may have to engage the patient in a discussion about methods of collecting this information in way that allows the patient to feel safe about being transparent. More often than not, my experience in a civil commitment setting demonstrates that patients will utilize these instruments in a manner that mimics that of community use.

FIT in a Private Practice Setting (Jim Reynolds)

The importance of a positive therapeutic alliance has been consistently described in the literature and is well known by treatment providers. However, no agency or organization where I have worked has actively measured the therapeutic alliance, much less incorporated aspects of the therapeutic alliance in the treatment planning/delivery processes. Consultation with colleagues suggests that this remains the general state of affairs within our field.

Implementing FIT into a solo, community-based practice is probably much easier than in agencies or large criminal-justice systems. I did not need to ask anyone's permission. I simply received training and implemented it without any difficulties. I was able to easily adjust the policies and procedures which guide the treatment I provide clients, incorporating important principles from FIT into the therapy I provide. For example, my clients are provided complete and unfettered access to theirtreatment records - within the boundaries of relevant ethical principles and practices. There is no paper work for them to complete. No board or committee needs to be consulted. A client only has to ask and they can see their case file.

FIT helps me to individualize treatment based on building client capacities and managing risks. I can structure treatment according to the priorities, goals,preferences, and progress of the individual client as those elements relate to the reason(s) for being in treatment. These goals are not imposed on the client, either by me or by a supervising entity such as probation or parole. Client feedback on the ORS and SRS is taken seriously, and used to monitor/modify the course and length of treatment in real time.

Collaborating with clients and being transparent in my interactions with them helps to create a positive "culture of feedback" in which client input and feedback are integrated into the therapeutic process. The ORS and SRS are valid, reliable, and "user friendly" outcome measures of alliance that I use to guide services throughout the therapy process. Using the ORS and SRS allows me to objectively monitor and chart each individual client's progress, to determine which clients are making progress and which are at risk for a negative or no change outcome.

Information from the ORS and SRS helps me identify problems/concerns in the therapeutic relationship that may compromise the effectiveness of treatment. Identifying and repairing problematic alliances can improve clients' motivation for treatment as well as their level of active engagement in therapy. I am able to use the information from the scales to adjust the level and type of care that I provide each client,

in both individual and group therapies, in order to be responsive to each client's perceived needs and treatment goals.

Overall, integrating FIT into a private practice can be easily accomplished. Doing so has allowed me to easily collect client outcome data in real time that I can then use to help guide the treatment process. I use that information to guide the focus of therapy, as well as the frequency with which I meet clients. I am able to objectively identify clients who have achieved an optimum level of functioning and appropriately titrate treatment. I can also identify clients who are not benefiting from treatment and, if adjustments to treatment are unsuccessful, make appropriate referrals to another provider.

Conclusion

At first, implementing FIT can be challenging for people working in criminal-justice settings. It involves creating a culture of feedback and being willing to listen to unflattering feedback in order to strengthen the alliance and improve outcomes. However, those who monitor their alliances and outcomes commonly report improved treatment progress, earlier detection of treatment problems and dropout, reduced client-driven complaints and grievances, and a seemingly endless resource for deep professional development and knowledge.

_____

References

Bertolino, B. & Miller, S.D. (Eds) (2013). *The ICCE Feedback Informed Treatment Manuals* (6 Volumes). ICCE: Chicago, Illinois.

Duncan, B., Miller, S.D., Wampold, B., & Hubble, M. (2010). *The heart and soul of change, second edition: Delivering what works in therapy.* Washington, DC: American Psychological Association.

Marques, J.K., Wiederanders, M., Day, D.M., Nelson, C., & van Ommeren, A. (2005). Effects of a relapse prevention program on sexual recidivism: Final results from California's Sex Offender Treatment and Evaluation Project (SOTEP). *Sexual Abuse: A Journal of Research & Treatment, 17,* 79-107.

Miller, S.D. & Bargmann, S. (2011). Feedback Informed Treatment (FIT): Improving outcome with male clients on man at a time. In J.A. Ashfield & M. Groth (Eds.),*Doing psychotherapy with men*. CreateSpace Independent Publishing Platform.

Miller, S.D., & Duncan, B. (2000). *The Outcome Rating Scale*. Chicago, Illinois: International Center for Clinical Excellence.

Miller, S.D., & Duncan, B. (2004). *The Outcome and Session Rating Scales Administration and Scoring Manual.* Chicago, Illinois: ISTC Press.

Miller, S.D., Duncan, B., & Hubble, M. (2004). Beyond integration: The triumph of outcome over process in clinical practice. *Psychotherapy in Australia, 10,* 2-19.

Miller, S.D., Duncan, B.L., Brown, J., Sparks, J., & Claud, D. (2003). The outcome rating scale: A preliminary study of reliability, validity, and feasibility of a brief visual analog measure. *Journal of Brief Therapy, 2,* 91-100.

Miller, S.D., Duncan, B.L., & Johnson, L.J. (2000). *The Session Rating Scale.* Chicago, Illinois: International Center for Clinical Excellence.

Miller, S.D., Hubble, M.A., Chow, D. & Seidel, J. (2013). The outcome of psychotherapy: Yesterday, today, and Tomorrow. *Psychotherapy, 50*, 88-97.

Miller, S.D., Hubble, M.A., & Duncan, B. (2007). Supershrinks: Learning from the field's most effective practitioners. *Psychotherapy, 31,* 27-35, 56.

Parhar, K.K., Wormith, J. S., Derkzen, D. M., & Beauregard, A. M. (2008). Offender coercion in treatment: A meta-analysis of effectiveness. *Criminal Justice and Behavior, 35,*1109 – 1135.

Prescott, D.S., & Levenson, J.S. (2009, summer). To treat or not to treat: What are the questions? *ATSA Forum, 21,* 19-28. Retrieved October 6, 2013

fromhttp://www.davidprescott.net/2009SumrForum_Prescott-Levenson.pdf.

Skeem, J.L., Louden, J., Polaschek, D., & Camp, J. (2007). Assessing relationship quality in mandated community treatment: Blending care with control. *Psychological Assessment, 19,* 297-410. Doi 10.1037/1040-3590.19.4.397.

White, W. & Miller, W. (2007). The use of confrontation in addiction treatment: History, science and time for change. *Counselor*, *8(4),* 12-30. Retrieved October 6, 2013 from http://www.williamwhitepapers.com/pr/2007ConfrontationinAddictionTreatment.pdf.