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Introducing Feedback Informed Preference Accommodation (FIPA): A Case Study in Clinical Practice

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Psychotherapy is a successful modality for those who engage in and complete a course of treatment. However, attrition rates and negative outcomes make up a significant and under discussed proportion of clinicians' case load in routine practice. Innovative and novel methods to address these issues have been identified within the extant literature. However, their uptake can be impacted by issues such as utility and brevity. The present paper seeks to establish a framework for integrating Feedback Informed Treatment (FIT) and the Cooper-Norcross Inventory of Preferences (C-NPI) in clinical practice. That is, using the C-NPI for initial preference accommodation and following this up on a session to session basis to monitor the process and outcome of therapy. An overview of both approaches is provided, and a rationale for their integration elucidated. The author terms this integration, Feedback Informed Preference Accommodation (FIPA). A Case Study is put forward to demonstrate this process in clinical practice.

KEYWORDS: Feedback Informed Treatment (FIT), Feedback Informed Preference Accommodation (FIPA), integration, case study

Feedback Informed Treatment

Incorporating client feedback and preferences into routine clinical practice has shown to be an effective way to reduce attrition and improve outcomes for those at risk of negative therapy experiences. Research suggests that these two phenomena account for a significant proportion of client experiences in therapy. For example, attrition rates are quite prevalent within routine practice, that is, the unilateral decision by our clients to terminate therapy average about 47% for those attending adult community outpatient services (Wierzbicki and Pekarik, 1993; Sparks, Daniels & Johnson, 2003). However, it is important to note that this is not necessarily a negative thing, some people fail to return because they are satisfied with the service that they have received (Talmon,1990).

In samples of young people attrition is anywhere between 17% to 85% (de Hann et al., 2013 Garcia and Weisz, 2002; Kazdin,1996). Moreover, it has been demonstrated that approximately 5-10% of adult clients deteriorate whilst in our care (Cuijpers, 2018; Hansen, Lambert & Foreman, 2002; Lambert, 2013). For children and adolescents these numbers average about 24% (Nelson et al., 2013). These statistics are especially problematic for both researchers and practitioners and impact upon the field's effectiveness as they occur in both naturalistic and clinical trial settings.

Feedback Informed Treatment (FIT) is one method put forward to help alleviate these negative client experiences, it involves the use of two ultra-brief scales that assess the clients experience of therapy process and outcome on a session to session basis, resulting feedback is used to adapt care based on client need and preferences. Indeed, Brattland et al (2018) demonstrated that clients of therapists using feedback are up to 2.5 times more likely to improve than those not receiving feedback.

Hafkenscheid, Duncan & Miller (2010) discuss two short four question instruments to measure and solicit feedback on a session to session basis. The Outcome Rating Scale (ORS) is a four item 10cm analog scale that captures data on the following client domains: individual, interpersonal, social and overall functioning. It is a global measure of well-being administered

at the beginning of each session and scored on a 0-40. Scores are then contextualised to the client's narrative of why they are seeking care and tracked weekly.

The Session Rating Scale (SRS) is a four-item instrument that assesses the quality of the therapeutic alliance, which is a key indicator of the effectiveness of therapy (Wampold, 2015). The four items on the SRS are consistent with Bordin (1979) theory of the therapeutic alliance. The SRS is administered towards the end of each session and captures the clients rating of the bond, agreement on tasks and goals and the methods used. Like the ORS, items are scored on a 10cm analog scale totalling 0-40 points. Both measures can be utilised with children, young people and adults with normative data indicating clinical cut-off. Their trans-theoretical underpinnings mean that they can be used in all manner of settings and with all presenting issues. To this end, the assessment instruments are a means to work through and solicit client feedback at each session in order to generate therapeutic dialogue and a culture of feedback which can subsequently utilised to adapt treatment for those at risk of negative outcomes.

While Feedback Informed Treatment (FIT) is associated with the utilisation of the Outcome Rating Scale and the Session Rating Scale, other types of instruments are also available to solicit client feedback. The ongoing clinical utility and brevity of the ORS and SRS is derived from their ultra-short time to administer and score, meaning practitioners are more likely use them on a session to session basis (Miller et al., 2006). However, this should not exclude other instruments, especially those that can provide additional clinical feedback and capture pre-therapy preferences clients may implicitly possess.

Preference Accommodation

The Cooper-Norcross Inventory of Preferences (2016) is an 18-item brief, multidimensional clinical tool to help clients articulate the therapist style they desire in counselling. The inventory has four overarching scales focusing on a client wishes for therapist directiveness vs. client directiveness, emotional intensity vs. emotional reserve, past orientation vs. present orientation, and warm support vs. focused challenge. This inventory can be completed as a paper-scale or as an online assessment which interprets and provides an automatic list of the type of therapy prospective clients wish to receive.

Substantial research has demonstrated the power of preference accommodation within therapy, it converges nicely with the research on the therapeutic alliance and FIT. Two key meta-analyses illustrate the effectiveness of preference accommodation and the way this can be achieved. Lindhiem et al (2014) systematically reviewed the literature and found that preference accommodation was associated with fewer dropouts, increased satisfaction and superior outcomes. Swift et al (2018) replicated these findings in their meta-analysis involving 53 studies with 16,000 clients, providing us with an effect size (d=0.28) for those included in the preference arm of the studies. Findings from both studies indicate the robust nature of preference accommodation regardless of some of the methodological factors that often moderate such findings.

However, given the relatively longer time to administer, the Cooper-Norcross Preference Inventory may lose some of its brevity and utility for regular ongoing use. Thus, a useful way to administer this inventory is to have a client complete it once before therapy begins, and then keep track of these personal preferences through the use of the SRS and the impact on outcome through the ORS on a session to session basis. The following mini Case Study provides an example from clinical practice and delineates how to use these assessment measures concurrently.

Case Study

Informed consent

The following clinical case study is drawn from the authors psychotherapeutic practice. All identifying information has been removed from the write up. The individual in question, provided consent for the author to utilise this experience for research purposes and publication. 'Dave' is a pseudonym, used in order to maintain confidentiality

Client Profile

Name: Dave
Age: 34
Gender: Male

Presenting Problem

Dave a 34-year-old male first contacted the therapy service seeking support last year. During the brief intake call to my practice, Dave explained to me that he had unsatisfactory relationships and was feeling very down and depressed. He also alluded to a rather traumatic childhood and growing up in a chaotic home. Dave was offered an appointment and was seen by myself. My theoretical orientation would best be described as pluralistic, and feedback informed.

Cooper-Norcross Inventory of Preferences

Before Dave engaged in further therapeutic dialogue, I asked him to complete the Cooper-Norcross Inventory of Preferences. After I explained its purpose, Dave completed the inventory, resulting data indicated that Dave had a strong preference for a supportive and past orientated therapy approach. I spoke to Dave about what this would look like in practice. I discussed my role in creating a safe and supportive space, where he could recall and work through possible painful memories and emotions and their impact on his present life and relationships. I affirmed Dave's preference and I made a point to refer to our initial phone conversation and that it made sense that he would wish to explore these painful issues.

Outcome Rating Scale

After the first 10-15 minutes, I introduced the Outcome Rating Scale (ORS), explained it purpose and asked Dave to score it. Dave scored a 10 on the ORS, indicating extreme distress. The clinical cut-off of 25 separates a clinical from non-clinical on the ORS. I thought a risk assessment was needed based on this score and directly, but sensitively asked Dave about his feelings and if he has any thoughts of harming himself. Dave replied that he has been having some 'dark thoughts' of late, but he doesn't think that he would follow through with them. These issues were explored, and support was offered to Dave in a sensitive present focused manner, focusing on safety planning and suicide ideation.

I then brought up the preference choices Dave provided, voicing concern that a backwards looking therapy approach may not be the best method at the present time due to the other crisis type issues Dave is experiencing. I further suggested that in my experience, things could possibly become more intense if we opened them up at the present time, however, they could be explored at a future point, which will happen in the coming weeks (building hope & expectancy). Dave agreed to this and a safety future orientated plan was collaboratively agreed on.

Session Rating Scale

Towards the end of the session, I introduced the SRS and explained its purpose. I was initially unsure whether to ask Dave to fill out this short measure. The deciding factor, other than Dave's willingness, was due to Dave's initial preference not being met, and I was aware that these

were not meet, albeit for good reason. Dave scored the SRS at 37, which is one above the cut-off of 36. The cut-off on the alliance is different that the ORS as it provides us with information on how happy a client is with the therapeutic alliance that we have cultivated with them. Clients tend to score alliance measures quite high, reflecting the cut-off of 36 on the SRS.I thanked Dave and asked if there was anything else that could be improved on, or a need not being met, or if things change to please let the therapist know.

At the next session Dave scored the ORS at 16, indicating that some reliable change had occurred, and he thanked me for the helpful emotional support and strategies that he had used throughout the previous week. However, as Dave was still under 25 on the clinical cut-off there was still some distress, this was affirmed by Dave. Getting conformation from Dave on what these scores represented was imperative, as they really are just a means of creating focused therapeutic dialog. Over the course of the next few sessions Dave's distress started to dissipate and scores on the ORS were on an upwards trajectory.

However, through week 4-7 there was a stagnation with no upwards movement. At the end of session 7 I administered the SRS to Dave and was both surprised and happy when the scores came back lower than ever before, 34, indicating that Dave was unsatisfied with some of the therapy and progress. I thanked Dave for the great feedback and enquired as to what was not working for him, the task and goals item were scored quite low. Dave suggested that he was feeling a bit better over the previous weeks and that he was now ready to engage more fully in a past orientated therapy process.

We spoke about this for a while and I informed Dave that he was well placed to develop his own direction and healing, I spoke to about my ethical considerations for him and his wellbeing and we agreed that if things change regarding his wellbeing that we would reconsider together the approach we were taking.

However, I also offered Dave to complete the Cooper-Norcross Inventory of Preference again, explaining that although he had established a previous preference, this may have changed slightly based on his experience of therapy and the therapist. While Dave declined this offer, I felt it was an important discussion to have. Always leaving on the table, the clients right to determine the direction of their therapy in conjunction with the therapist.

Discussion

The incorporation of feedback informed approaches and preference accommodation represent novel and evidence-based methods of shared decision making within the therapy process. Client attrition and negative outcomes are reduced due to such processes, and better client outcomes result from privileging the client's feedback and wishes in the therapy encounter. While there are many measures available to solicit feedback, the present paper has sought to demonstrate the use of Feedback Informed Treatment (FIT) in conjunction with the Coop-Norcross Inventory of Preferences as they represent two ways to incorporate substantive preferences that can be monitored with ease on a session to session basis. Clinical case presentation can be best served by utilising these instruments in an integrative manner. We term this way of working, Feedback Informed Preference Accommodation (FIPA). Practitioners may wish to consider the benefit of integrating these trans-theoretical approaches into routine care, as they offer a unique insight into the clients' world, and have utility and feasibility for the average practitioner.

The present article is the first known articulation of the integration of both constructs. Thus, it adds to the existing body of literature in a novel way and extends the practice of both feedback informed approaches and preference accommodation in clinical practice.

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